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 _____	C 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**

(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) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ00162613, NJ00167128, NJ00167131, NJ00156127, NJ00150193, NJ00168198, NJ00170075, NJ00153967, NJ00170677 Survey Date: 4/3/24 Census: 135 Sample: 46 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		5/31/24

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

Electronically Signed | 05/03/2024

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.

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F 640	Continued From page 1 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete the	F 640	How the corrective action will be accomplished for those residents found to	

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F 640	Continued From page 2 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 NJ Exec Order 2 and was due to be completed no later than NJ Exec Order 2. The MDS was not completed until NJ Exec Order 26. 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 NJ Exec Order 2 and was due to be completed no later than NJ Exec Order 2. The MDS was not completed until NJ Exec Order 2. According to the latest version of the Center for Medicare/Medicaid Services - Resident	F 640	have been affected by the practice - Resident # 10 Discharged MDS was completed and transmitted on NJ Exec Order 2 - US FOIA (b)(6) was inserviced on timely submission of MDS in accordance with the federal guideline. - All residents' MDS will be reviewed for compliance. Any identified discrepancies will be corrected immediately. How the facility will identify other residents having the potential to be affected by this practice. - Resident #10 was not affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur - MDS audit will be done on all active and discharged residents to ensure that discharged MDS are completed and transmitted in a timely manner. - All active and discharged residents will be reviewed during the morning report by the Interdisciplinary Team to ensure that discharge MDS are completed and submitted timely. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur i.e. what quality	

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F 640	Continued From page 3 Assessment Instrument (RAI) 3.0 Manual (updated October 2023) page 2-16 reflected under Admission (Comprehensive) with a MDS Completion Date which stated "admission date + 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 U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]. There was no further information provided. 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.	F 640	assurance program will be put into place. - Systematic MDS audits for all active and discharged residents will ensure discharged MDS are completed and transmitted timely. - MDS completion and transmission audit for active and discharged residents will be carried out by MDS coordinator/designee weekly for 4 weeks, then monthly x 2 months. - Findings will be discussed in morning meetings and during monthly and quarterly QAPI meetings to ensure no recurrence of deficiency.	
F 641 SS=C	NJAC 8:39 - 11.1 Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an	F 641	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	5/31/24

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F 641	Continued From page 4 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 [redacted] and [redacted]. 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, [redacted]. A review of a Quarterly MDS assessment, dated [redacted], indicated the facility completed a Brief Interview for Mental Status (BIMS) with Resident #33. The resident scored a [redacted] out of 15 which indicated the resident had [redacted]. In Section [redacted], [redacted], under [redacted], Resident #33 was coded as using [redacted]. A review of the Order Summary Report included a physician's order dated [redacted] which read, "[redacted] On 3/21/24 at 12:39 PM, the surveyor interviewed LPN #1 about Resident #33. LPN#1 stated	F 641	AFFECTED BY THE PRACTICE -Resident #33 - Quarterly MDS assessment was corrected and completed on [redacted] -Resident #95 - Quarterly MDS was corrected and completed on [redacted] -Resident #32 - Quarterly MDS was corrected and completed on [redacted] -Resident #133 MDS was corrected and completed on [redacted] -[redacted] was inserviced on accurate completion of MDS/MDS assessment and Interdisciplinary Team were also inserviced on accurate completion of the MDS assessment Comprehensive training for [redacted] and designee on the importance of accurate MDS completion -All residents MDS assessments reviewed to ensure compliance -Resident # 33 was not affected by this deficient practice. -Resident # 95 was not affected by this deficient practice. -Resident # 32 was not affected by this deficient practice. -Resident # 133 was not affected by this deficient practice. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE -All Residents have the potential to be affected by this practice.	

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F 641	Continued From page 5 residents had NJ Exec Order 26.4b1 to be used as an NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 while in bed. LPN #1 stated the resident was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 [redacted] The surveyor went with LPN #1 in the room to observe the NJ Exec Order 26.4b1 Resident #33 was out of bed in the reclining chair. The resident's bed was observed with upper, NJ Exec Order 26.4b1. LPN# 1 stated the resident had NJ Exec Order 26.4b1 used as NJ Exec Order 26.4b1 [redacted] On 3/21/24 at 1:09 PM, the surveyor interviewed MDS Coordinator #1 who stated NJ Exec Order 26.4b1 were used to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1 in the hallway NJ Exec Order 26.4b1 with staff supervision. The resident was NJ Exec Order 26.4b1. The surveyor observed the resident's bed NJ Exec Order 26.4b1 [redacted] On 3/21/24 at 9:40 AM, the surveyor reviewed Resident #95's hybrid (paper and electronic) medical records. The Admission Record (AR) documented the resident had diagnoses that included but were not limited to, NJ Exec Order 26.4b1. A review of a Quarterly MDS assessment, dated NJ Exec Order 26.4b1 indicated the facility completed a Brief	F 641	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. -MDS audit will be done on all active and discharge residents to ensure that all MDS are accurately completed in a timely manner. -All active and discharged residents will be reviewed during the morning report by the Interdisciplinary Team to ensure that all MDS are completed and submitted accurately and timely. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE -MDS accuracy and transmission audit for active and discharged residents will completed by the MDS Coordinator/designee weekly x 4 weeks, and then monthly x 2 months. -Any findings will be reported to the Administrator and DON and discussed in morning meeting -MDS audits findings will also be discussed during the monthly and quarterly QAPI meetings.	

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F 641	Continued From page 6	F 641		

Interview for Mental Status (BIMS) with Resident #95. The resident scored a [redacted] out of 15 which indicated the resident had [redacted]. In [redacted], under [redacted], Resident #95 was coded as using [redacted].

A review of the Order Summary Report included a physician's order dated [redacted] which read, "[redacted]".

On 3/21/24 at 12:39 PM, the surveyor interviewed LPN # 1 about Resident #95. LPN # 1 stated the resident was [redacted] with [redacted] and [redacted]. The surveyor went with LPN # 1 to observe Resident #95's bed. The resident's [redacted] in use. LPN# 1 explained the resident was [redacted] and [redacted] and [redacted].

On 3/21/24 at 1:09 PM, the surveyor interviewed MDS Coordinator #1 who stated [redacted] were used to [redacted] and [redacted] 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 [redacted] as a [redacted] was an error. MDS coordinator #1 stated the MDS assessment would be corrected.

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 [redacted]

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NJ Exec Order 26.4b1. The surveyor also observed that Resident #32 was in the process of receiving NJ Exec Order 26.4b1

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 NJ Exec Order 26.4b1.

A review of the Quarterly MDS (Q/MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b reflected that the resident had a BIMS score of NJ Ex out of 15 indicating that the resident had NJ Exec Order 26.4b1

A review of the NJ Exec Order 26.4b1 Treatment Administration Record revealed a physician's order dated NJ Exec Orde for "NJ Exec Order 26.4b1 which were signed by the nurses indicating that the NJ Exec Order 26.4b1 care was done.

Further review of the Q/MDS under Section NJ Exec Order 26.4b1 Care which was coded "NJ Exe".

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.

On 3/26/24 at 10:15 AM, the U.S. FOIA stated to the

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F 641	Continued From page 8	F 641		

surveyor that it was coded in error.

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 U.S. FOIA (b) (6)) Discharge Plan Documentation (DPD) created on NJ Exec Order 26.4b by the US FOIA for Resident #133. The DPD documented that Resident #133 was discharged home with family.
Review of the NJ Exec Order 26.4b1 Nursing Progress Note (PN), indicated that Resident #133 " NJ Exec Order 26.4b1 "

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 NJ Exec Order 26 with diagnosis that included but were not limited to NJ Exec Order 26.4b1 NJ Exec Order 26.4b1

Review of the "A section" of the NJ Exec Order 26.4b Discharge MDS for Resident #133 revealed that section NJ Exec Order 26.4b1 " documented, "NJ Exec Order 26.4b1

On 3/25/24 at 10:39 AM, the surveyor interviewed the US FOIA (b)(6). The US FOIA (b)(6) stated, "That resident NJ Exec Order 26.4b1. 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

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F 641	Continued From page 9 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 U.S. FOIA (b) (6) [redacted] 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 U.S. FOIA (b) (6) [redacted]) and U.S. FOIA [redacted] to discuss the MDS coding error. The U.S. FOIA [redacted] 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)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		5/31/24

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F 658	Continued From page 10 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 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 [redacted] unit. RN#1 prepared medication for Resident #186 who had a Physician Order (PO) for [redacted] daily for [redacted] with [redacted]	F 658	1- RN #1 was re-educated on [redacted] and [redacted] policy and medication administration. The nurse received a new medication competency on [redacted]. [redacted] noted to the resident #186. 2- The facility recognizes the risk that residents could potentially be affected by the stated deficient practice. 3- Licensed nurses will be re-educated by the Nurse Practice Educator or designee on proper protocol for verification of parameters and medication policy. 4- The Director of Nursing or designee will do weekly audits for one month followed by monthly audits for another two months. 5- Audit results will be reported at the quarterly Quality Assurance meetings. -The administrator will take corrective action as needed.	

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[redacted] and NJ Ex Order 26.4b1 started on [redacted].

RN#1 proceeded to review the [redacted] and [redacted] 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 [redacted] was [redacted] and the [redacted] was [redacted] 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 [redacted] and [redacted] prior to administering the NJ Ex Order 26.4b1 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 NJ Ex Order 26.4b1 [redacted]

A review of Resident #186's Comprehensive Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that Resident #10 had a Brief Interview for Mental Status score of [redacted] out of 15, indicating [redacted].

The surveyor reviewed of Resident #186's Care Plan initiated on [redacted] and titled, "Resident #186 exhibits or is at risk for NJ Ex Order 26.4b1 [redacted] related to diagnosis of NJ Ex Order 26.4b1 [redacted]

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 _____	C 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

(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) COMPLETION DATE
F 658	Continued From page 12 NJ Exec Order 26.4b1 The documented "Goal" was, Resident #186's NJ Exec Order 26.4b1 will remain within NJ Exec Order 26.4b1 "Interventions" included, "Assess and monitor NJ Ex Order 26.4b1 to physicians." 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 U.S. FOIA (b) (6) and U.S. FOIA (b) (6) of the issue. There was no additional information provided. NJAC 8:39 - 27.1	F 658		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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: Complaint #NJ00170677 Complaint #NJ00156127 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	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. - 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	5/31/24

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

Electronically Signed | 05/03/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the	S 560	- 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 the New Jersey staffing mandate " Center will continue recruiting functions, which drive various forms of media to increase the number of applicants: - Continue with and expand recruitment efforts through various media channels to increase the number of potential job applicants. - Continue with targeted advertising campaigns on social media, local job boards, community newspapers, and participate in job fairs. - Signs posted throughout facility offering large bonuses to new hires and those employees that refer them. -Continue to form partnerships with local nursing schools and educational programs to facilitate student training and transition into certified nursing assistants (CNAs). - Continue with weekly staffing calls with the regional support team to discuss staffing needs and strategies. - Continue with weekly teleconferences to assess staffing metrics, review recruitment progress, and adjust strategies as necessary.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for 3 segment dates that related to the standard survey and complaints revealing the following: 1. For the week of staffing reviewed from 7/10/2022 to 7/16/2022, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in CNAs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -07/10/22 had 11 CNAs for 131 residents on the day shift, required at least 16 CNAs. -07/11/22 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -07/12/22 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -07/13/22 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs. -07/14/22 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -07/14/22 had 7 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -07/14/22 had 6 total staff for 132 residents on the overnight shift, required at least 9 total staff. -07/15/22 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs.	S 560	- 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. Continue to discuss staffing levels and strategies at quarterly Quality Assurance meetings to ensure ongoing compliance and identify areas for improvement. - 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 -07/16/22 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. 2. For the week of staffing reviewed from 1/21/2024 to 1/27/2024, the facility was deficient in CNA staffing for residents on 7 of 7 day shift and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -01/21/24 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/22/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/22/24 had 4 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. -01/23/24 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/24/24 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/25/24 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/26/24 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/27/24 had 12 CNAs for 134 residents on the day shift, required at least 17 CNAs. 3. For the 2 weeks of staffing prior to survey from 3/03/2024 to 3/16/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/03/24 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/04/24 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/05/24 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -03/06/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. -03/07/24 had 13 CNAs for 128 residents on the	S 560		

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 _____	C 04/03/2024

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S 560	Continued From page 4 day shift, required at least 16 CNAs. -03/08/24 had 11 CNAs for 128 residents on the day shift, required at least 16 CNAs. -03/09/24 had 14 CNAs for 128 residents on the day shift, required at least 16 CNAs. -03/10/24 had 13 CNAs for 128 residents on the day shift, required at least 16 CNAs. -03/11/24 had 9 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/12/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/13/24 had 10 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/14/24 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/15/24 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -03/16/24 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. On 3/21/24 at 12:44 PM, the surveyor discussed the staffing ratio concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing. The LNHA replied, "we're trying very hard to meet the daily facility staffing needs required." The LNHA added, "we're continuously working on the staffing issue."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315328	A. Building B. Wing	6/6/2024

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 F0640 Reg. # 483.20(f)(1)-(4) LSC	Correction Completed 05/31/2024	ID Prefix F0641 Reg. # 483.20(g) LSC	Correction Completed 05/31/2024	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/31/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
4/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060224 (Y1)	A. Building B. Wing (Y2)	6/6/2024 (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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
4/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315328	A. BUILDING **01** 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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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/02/2024 and 04/03/2024 Maple Glen Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Maple Glen Center is a 1-story building with a partial basement that was built in 90's, It is composed of Type I fire resistant construction. The facility is divided into 10- smoke zones. The generator does approximately 50 % of the building. The facility has 159 certified beds. At the time of the survey the census was 135.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at	K 222		5/3/24

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

Electronically Signed | 05/03/2024

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F 658		F 658		

Continued From page 11

NJ Exec Order 26.4b1 .

RN#1 proceeded to review the NJ Exec O and NJ Exec 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 NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 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 NJ Exec Order 26.4 and NJ Exec Order 26.4b1 to administering the NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1

A review of Resident #186's Comprehensive Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26, reflected that Resident #10 had a Brief Interview for Mental Status score of NJ Exe out of 15, indicating NJ Exec Order 26.4

The surveyor reviewed of Resident #186's Care Plan initiated on NJ Exec Order 26.4b1 and titled, "Resident #186 exhibits or is at risk for NJ Exec Order 26.4b1 symptoms or complications related to diagnosis of NJ Exec Order 26.4b1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MAPLE GLEN CENTER	**12-15 SADDLE RIVER ROAD** **FAIRLAWN, NJ 07410**

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K 222	Continued From page 2 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 04/02/2024 and 04/03/2024, it was determined that the facility failed to provide 1 of 9 designated exit access /discharge (illuminated exit signs above door) doors with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with nine (9) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 in the presence of the facility's US FOI a tour of the building was conducted. On 04/02/2024 at approximately 11:22 AM, the	K 222	1. Maintenance Supervisor PERMANANTLY disabled the EGRESS LOCK leading to the Lobby this was Completed 4/29/24. There were no other doors affected. 2. Every resident or staff has the potential to be affected by this deficient practice. 3. The Maintenance Supervisor or designee will make weekly rounds and will check all doors and complete in Tels report and then report to the QA Committee monthly X12 months. 4. Admistrator will continue educating and following up with maintenance to encure task is completed and reported weekly in am meeting.	

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K 222	Continued From page 3 surveyor observed the one set of corridor access doors (illuminated exit signs above the double doors) leading into the main lobby revealed a thumb turn lock on the egress side of the doors. The thumb turn lock and fastening device on the door could restrict emergency use of the designated exit discharge doors. A review of an emergency evacuation diagram posted in the corridor identify the set of double access doors are the primary doors to reach an exit discharge door in the event of an emergency. The [US FOIA] confirmed the findings at the times of observation. The [US FOIA (b)(6)] was informed of the deficiency during the survey exit on 04/03/2024 at approximately 1:01 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/02/2024 and 04/03/2024 in the presence of facility management, it was determined that the facility failed to: Provide a functioning battery backup emergency lighting in 1 of 1 rooms the emergency generator's transfer one (1) switch location, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1.	K 291	1. On 4/29/24 the Maintenance Director contacted [NJ Ex Order 26.4(] regarding the need to install a emergency battery back up light in the generator room. 2. The vendor [NJ Ex Order 26.4(] will deliver the part and it will arrive the week of 5/5/24 and [NJ Ex Order 26.4(b)(1)] will install the BACKUP EMERGENCY battery by	5/15/24

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K 291	Continued From page 4 This deficient practice was evidenced by the following: On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested, does the facility have an emergency generator. The US FOIA told the surveyor, yes we have an Diesel Emergency Generator. Starting at approximately 9:42 AM on 04/02/2024 in the presence of the facility US FOIA a tour of the building was conducted. At approximately 10:32 AM an inspection of the Emergency Generator's Kohler transfer switch was performed. The surveyor observed no evidence of a battery back-up emergency light for the transfer switch. At this time the surveyor asked the US FOIA "Does the facility have a battery back-up emergency light here for the transfer switch." The US FOIA looked around and told the surveyor, no. This finding was verified by the facility's US FOIA (b)(6) during the observation. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 04/03/2024 at approximately 1:01 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	5/15/24 3. Maintenance staff will add to their monthly battery light back up log to ensure testing is completed on a monthly schedule and reported to the Administrator and QAPI meeting monthly x6 months.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING	K 293		5/15/24

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K 293	Continued From page 5 Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 04/02/2024 and 04/03/2024 in the presence of facility management, it was determined that the facility failed to: 1) To provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical	K 293	1. NJ Ex Order 26.4b1 will install the ILLUMINATED EXIT ACCESS SIGNS to be completed 5/15/24 in the following areas: A. ABOVE the CORRIDOR DOUBLE DOORS next to resident room 303 B. ABOVE the CORRIDOR DOUBLE DOORS next to resident room 100. 2. All residents and staff have the potential to be affected by this deficient practice. 3 Maintenance will round daily and check all hall Exit lights to make sure they founction correctly and reviewed in QAPI monthly x6 months	

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K 293	Continued From page 6 and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-four (64) Resident sleeping rooms, common areas and offices. There are nine (9) designated exit discharge doors that Residents, Visitors and Staff could use to exit the building in the event of an emergency. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 presence of the facility's US FOIA (b)(tour of the building was conducted. During the two (2) day building tour the surveyor observed the following locations that failed to provide illuminated exit signs to clearly identify the exit access path to reach an exit,	K 293		

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K 293	Continued From page 7 1) On 04/02/2024 at approximately 11:49 AM, the surveyor observed no evidence of an illuminated exit sign above the corridor double smoke doors next to Resident room #303. When the fire alarm system is activated the smoke doors release from their magnetic hold open devices, close into their frame and you would not be able to see the illuminated exit sign on the other side of the smoke doors further down the corridor. 2) On 04/03/2024 at approximately 11:55 AM, the surveyor observed no evidence of an illuminated exit sign above the corridor double smoke doors next to Resident room #100. When the fire alarm system is activated the smoke doors release from their magnetic hold open devices, close into their frame and you would not be able to see the illuminated exit sign on the other side of the smoke doors further down the corridor. The [US FOIA] confirmed the finding at the time of observation. The [US FOIA (b)(6)] was informed of the Life Safety Code deficiency during the survey exit on 04/03/2024 at approximately 1:01 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101	K 351		5/3/24

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K 351	Continued From page 8 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation on 04/02/2024 and 04/03/2024, in the presence of facility management it was determined that: The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which	K 351	1. On 4/29/24 the maintenance Director replaced the escheon caps in the Basement MATERIALS MANAGEMENT OFFICE and in room 109 2. Every resident has the potential to be affected by these deficient practices. 3. The administrator spoke with maintenance supervisor regarding the significance of the escuheon caps being in place. 4. The Maintenance Supervisor or designee will round weekly checking for missing escuheon caps and report in the am meeting and monthly QAPI meeting monthly X6 months	

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K 351	Continued From page 9 identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building, two basements and sixty-four (64) Resident sleeping rooms, common areas and offices. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 presence of the facility's[US FOIA] a tour of the building was conducted. During the two (2) day building tour of the facility the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: 1) On 04/02/2024 at approximately 10:20 AM, an inspection inside the basement level Materials Management are the surveyor observed the fire sprinkler had no escuheon cap, leaving an approximately 3/8 inch gap around the sprinkler. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. 2) On 04/03/2024 at approximately 11:449 AM, an inspection inside Resident room #109 closet the surveyor observed the fire sprinkler had no escuheon cap, leaving an approximately 3/8 inch gap around the sprinkler. With the opening in the ceiling, in the event of a fire the heat would by pass the fire sprinkler in the area and not activate the fire sprinkler system. The [US FOIA] confirmed the findings at the time of observations. The[US FOIA (b)(6)] was informed of the deficiency during the Life Safety Code survey exit on 04/03/2024 at approximately 1:01 PM. Fire Safety Hazard.	K 351		

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K 351	Continued From page 10 NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 04/02/2024, 04/03/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 20 of 27 portable fire extinguishers observed and inspected. 2) Install portable fire extinguishers with-in the required height for 1 of 27 fire extinguishers observed, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.	K 355	1. On 4/2/24 all fire extinguishers in the building were checked and correctly dated by maintenance staff. 2. On 4/3/24 maintenance team were educated and inserviced by the administrtaor on the significance of not checking and dating all fire extinguishers monthly. 3. Every resident and staff has the potential to be affected by these deficient practices. 4. Maintenance team or designee will round monthly and check and correctly lable all fire extinguishers in the building. 5. Every month this audit will be entered into TELS TASK BY MAINTENANCE SUPERVISOR 6`This audit will be reported to the monthly QA committee x12 months	5/3/24

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K 355	Continued From page 11 - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Reference #2 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. The findings include the following, On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with twwo basements. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 in the presence of	K 355		

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K 355	Continued From page 12 the facility's [redacted] a tour of the building was conducted. Along the two (2) day tour the surveyor observed and inspected twenty-seven (27) fire extinguishers in various locations that were last annually inspected January 2024 with the following issues that were identified: On 04/02/2024: 1) At approximately 10:40 AM, One (1) "ABC-Type" fire extinguisher inside the Basement level Elevator Mechanical room was last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for February and March 2024. 2) At approximately 10:48 AM, One (1) ABC-Type fire extinguisher inside the Physical Therapy area last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 3) At approximately 11:01 AM, One (1) ABC-Type fire extinguisher to the right of the Employee lounge area last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 4) At approximately 11:05 AM, One (1) ABC-Type fire extinguisher near the Director of Environmental Services office last annually inspected January 2024. There was no evidence of monthly visual	K 355		

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K 355	Continued From page 13 examination performed and documented for March 2024. 5) At approximately 11:10 AM, One (1) ABC-Type fire extinguisher inside the Kitchen dry storage room last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 6) At approximately 11:12 AM, One (1) ABC-Type fire extinguisher inside the Electrical/ TV room last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 7) At approximately 11:16 AM, One (1) ABC-Type fire extinguisher inside the Maintenance Office last annually inspected January 2024. At this time the surveyor asked the [redacted] is this fire extinguisher a spare extinguisher. The [redacted] told the surveyor, yes it is. There was no evidence of monthly visual examination performed and documented for February and March 2024. 8) At approximately 11:18 AM, One (1) ABC-Type fire extinguisher (facility ID #16) inside the Medical Records room last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 9) At approximately 11:31 AM, One (1) Class "[redacted]" chemical fire extinguisher in the main	K 355		

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K 355	Continued From page 14 Kitchen last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. This fire extinguisher appeared to be mounted too high. The surveyor observed, measured and recorded this fire extinguisher was mounted 5'-7" to the center of the pressure indicator gauge. 10) At approximately 11:41 AM, One (1) ABC-Type fire extinguisher in the Residents Dining room last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 11) At approximately 11:45 AM, One (1) ABC-Type fire extinguisher in the Residents Living room area last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 12) At approximately 11:45 AM, One (1) ABC-Type fire extinguisher in the Residents Living room area last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 13) At approximately 12:15 PM, One (1) ABC-Type fire extinguisher in the corridor next to the elevator last annually inspected January 2024. There was no evidence of monthly visual	K 355		

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	315328	A. BUILDING **01** 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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K 355	Continued From page 15 examination performed and documented for March 2024. On 04/03/2024: 14) At approximately 10:23 AM, One (1) ABC-Type fire extinguisher in the corridor to the right of Resident room #420 last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 15) At approximately 10:50 AM, One (1) ABC-Type fire extinguisher in the corridor between Resident rooms #314 and #312 last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 16) At approximately 10:56 AM, One (1) ABC-Type fire extinguisher at the 300's Nursoing Station last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 17) At approximately 11:01 AM, One (1) ABC-Type fire extinguisher in the corridor to the right of Resident room #209 last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 18) At approximately 11:37 AM, One (1) ABC-Type fire extinguisher in the corridor to the right of Resident room #201 last annually inspected January 2024.	K 355		

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K 355	Continued From page 16 There was no evidence of monthly visual examination performed and documented for March 2024. 19) At approximately 11:37 AM, One (1) ABC-Type fire extinguisher in the corridor to the right of Resident room #106 last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. 20) At approximately 11:56 AM, One (1) ABC-Type fire extinguisher in the corridor to the right of Resident room #105 last annually inspected January 2024. There was no evidence of monthly visual examination performed and documented for March 2024. The facility[US FOIA] confirmed the findings at the time of observations. The[US FOIA (b)(6)] was informed of the Life Safety Code deficiency on 04/03/2024 at approximately 1:01 PM. FPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered	K 363		5/30/24

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K 363	Continued From page 17 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 04/02/2024 and 04/03/2024, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 32 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition,	K 363	1. On 5/3/24 [redacted] was contacted to order the part smoke seal for 2 and 3/8 inch gap to seal it and we also ordered a door sweep for the bottom of the door . 2. On 5/3/24 a door replacement was	

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K 363	Continued From page 18 Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was evidenced by the following, On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-four (64) Resident sleeping rooms, common areas and offices. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 presence of the facility's US FOIA a tour of the building was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the thirty-two (32) doors in the corridors with the following results, On 04/03/2024: 1) At approximately 11:07 AM, during a closure test of the Storage room near Resident room #400, the surveyor observed, measured and recorded a 3/8" by 2-1/2"section of the doors frame was missing. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. A review of an Emergency Evacuation diagram posted in the corridor identified to pass this room would be the primary and /or secondary exit	K 363	ordered 30W x 80L was ordered from HD SUPPLY and will be deivered on 5/7/24. 2. Once the parts are received it will be placed on the door. This will be completed by 5/30/24 3. Maintenanc will perform complete site inspection to determine no furter issues X6 months.	

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K 363	Continued From page 19 access route to reach an exit. The facility[US FOIA] confirmed the findings at the time of the observations. The[US FOIA (b)(6)] was informed of the Life Safety Code deficiency during the survey exit on 04/03/2024 at approximately 1:01 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 04/02/2024 and 04/03/2024, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for 1 of 4 sets of corridor smoke	K 374	1. 4/16/24 [NJ Ex Order 26.4(] was contacted regaing ordering a door mechanism and lock to Replace the door closer and repair defects on . Smoke Barrier Door near room 100 is to be replaced by 5/30/24	5/30/24

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K 374	Continued From page 20 barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with a basement. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 in the presence of the facility's US FOIA a tour of the building was conducted.. During the two (2) day building tour the surveyor observed and tested four (4) sets of corridor double smoke doors with the following results, On 04/03/22024: 1) At approximately 13:39 AM, during a closure test of the double smoke doors near the 100's Unit, when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed, measured and recorded a 3/8' by 3" section of one of the smoke doors was broken and missing. This would allow the transfer of smoke, fire and	K 374	2.Maintenance team will round daily to check all fire doors for safety 3. All residents and staff have the potential to be effected by this deficient practice. 4. Maintenance team will report to the QA meeting monthly x6 months	

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K 374	Continued From page 21 poisonous gasses to pass from one smoke compartment to another in the event of a fire. The [US FOIA (b)(6)] confirmed the findings at the time of observations. The [US FOIA (b)(6)] was informed of the Life Safety Code deficiency on 04/03/2024 at approximately 1:01 PM. Life Safety Code 101, 2012 Edition. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 04/02/2024 and 04/03/2024 in the presence of facility management, it was determined that the facility failed to : 1) Ensure that the facility's ventilation systems were being properly maintained for 4 of 10 Resident room/ Shower bathrooms exhaust systems, 2) Provide ventilation for 1 of 10 Resident bathrooms, as per the National Fire Protection Association (NFPA) 90A.	K 521	1. On 4/30/24 the exhaust System was fixed in following areas : A. On 4/30/24 Physical Theraphy ADL bathroom exhaust was installed. On 5/30/24 this ADL bathroom will be vented B. On 4/30/24 Room 300's Bathroom was vented. C. on 4/30/24 RM 405's bathroom D. On 4/30/24 Room 300's Resident	5/30/24

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K 521	Continued From page 22 This deficient practice was evidenced by the following: On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked the US FOI, how many Resident sleeping rooms are in the facility. The US FOIA didn't know how many Resident sleeping rooms. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-four (64) Resident sleeping rooms, common areas and offices. Starting at approximately 9:42 AM on 04/02/2024 and continued on 04/03/2024 in the presence of the facility's US FOIA a tour of the building was conducted. Along the two (2) day building tour, the surveyor inspected Ten (10) Resident bathrooms and Shower rooms.. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 10 resident bathrooms in the following locations: On 4/02/2024: 1. At approximately 10:27 AM, inside the Physical Therapy ADL Resident bathroom the surveyor observed no evidence of an exhaust	K 521	shower bathroom was vented. E. Shower room used as a lab will be vented by 5/30/24 2. Maintenance will do weekly rounds to check all air vents in the building and place in Tels. 3. All repairs will be reported to the QA Committee monthly x6 months.	

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K 521	Continued From page 23 system. This bathroom had no window with an area that would open for ventilation. This bathroom would rely on mechanical ventilation. 2. At approximately 11:35 AM, inside Resident room #300 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 11:57 AM, inside Resident room #405 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. On 04/03/2024: 4. At approximately 11:08 AM, inside Unit 300 Resident shower bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:30 AM, inside the shower room being used as a Lab, when tested the exhaust system did not function properly. This Lab had no window with an area that would open. This bathroom would rely on mechanical ventilation. The US FOIA confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 04/03/2024 at	K 521		

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K 521	Continued From page 24 approximately 1:01 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation on 04/02/2024, in the presence of facility management, it was determined that the facility failed: 1) To ensure that fire rated doors fully function properly, in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. The findings include the following, On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke	K 761	1. On 5/10/24 maqintenance Director will repair the metal plate and fire cork to seal and repair fire damper in boiler area in basement. . 2. This deficent practice has the potential to affect all residents and staff. 3. Maintenance will check monthy to make sure all is secure and report all findings to the QA committee x6 monthd.	5/15/24

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K 761	Continued From page 25 compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with two basements. Starting at approximately 9:42 AM on 04/02/2024 in the presence of the facility's MS a tour of the building was performed. At approximately 10:55 AM an inspection in basement #2 boiler room was performed. The surveyor observed that the corridor 1-1/2 hour fire rated door's 23 inch by 23 inch fire damper in the door was damaged leaving an opening from the boiler room into the exit corridor. In the event of a fire this would allow fire, smoke and poisonous gases to pass from the boiler room into the exit corridor. The [redacted] confirmed the finding at the time of observation. The [redacted] was informed of the deficiency during the survey exit on 04/03/2024 at approximately 1:01 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99)	K 911		5/15/24

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K 911	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation on 04/02/2024 and 04/03/2024, in the presence of the US FOIA (b)(6) [redacted]), the facility did not ensure guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas for 2 open electrical panels observed. 1). On 04/02/2024 at approximately 11:41 AM, the surveyor and US FOIA [redacted] observed an open electrical wall panels to the right of Resident room #210 was open to the corridor. Further inspection the surveyor observed clear tape covering a 3/4" by 2-1/4" opening in the cover plate leading to the live electric power. 2) On 04/03/2024 at approximately 11:41 AM, the surveyor US FOIA (b)(6) [redacted] observed an open electrical wall panel between Resident rooms #307 and #308 was open to the corridor. Further inspection the surveyor observed black electrical tape covering a 3/4" by 2-1/4" opening in the cover plate leading to the live electric power. The observations were confirmed by the US FOIA [redacted] during the tour of the facility. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 04/03/2024 at approximately 1:01 PM.	K 911	1. NJ Ex Order 26.4(b)(1) [redacted] will repair the electrical panels to be completed 5/15/24 : In corridor to the right of rooms #210, #307, #308. 2. Administrator Regional maintenance educated maintenance staff on the significance of keeping the panels repaired. 2. This deficient practice has the potential to affect all residents and staff 3. Maintenance team will evaluate and visually inspect monthly and report to monthly QAPIx6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315328	A. BUILDING **01** 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**

(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) COMPLETION DATE
K 911	Continued From page 27 NJAC 8:39-31.2(e) NFPA 70, 99	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA	K 918		5/15/24

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	315328	A. BUILDING **01** B. WING _____	**04/03/2024**

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K 918	Continued From page 28 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 04/02/2024 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 04/02/2024 (day one of survey) during the survey entrance at approximately 9:24 AM, a request was made to the US FOIA (b)(6) r and US FOIA (b)(6) if the facility had an Emergency Generator. The US FOIA told the surveyor, yes we have one 400 KW Diesel Emergency Generator. Starting at approximately 9:41 AM on 04/02/2024 in the presence of the facility's US FOIA during a tour of the building with the US FOIA at approximately 110:32 AM, an inspection in the basement of the building, where the Diesel Emergency Generator was located was performed. The surveyor observed no evidence of a remote emergency stop button. At this time the surveyor asked the US FOIA (Do you have a remote emergency stop button for the generator. The US FOIA said, no. The US FOIA confirmed the findings at the times of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 04/03/2024 at approximately 1:01 PM.	K 918	1. Maintenance Supervisor notifed NJ Ex Order 26.4(b)(1) 4/29/24. 2. NJ Ex Order 26.4 will place a REMOTE EMERGENCY STOP SWITCH on the Emergency Generator to be completed 5/15/24 3. Every resident has the potential to be affected by this deficient practice 4. Maintenance team will round weekly to ensure the correct founcting of the "STOP SWITCH" and report in TELS. This will be reported in the Morning Meeting and brought to the QAPI Meeting x12 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315328	A. BUILDING **01** 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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K 918	Continued From page 29 NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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 01 - MAIN BUILDING 01 B. Wing Y2	6/6/2024 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	05/03/2024	LSC K0291	05/15/2024	LSC K0293	05/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	05/03/2024	LSC K0355	05/03/2024	LSC K0363	05/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0374	05/30/2024	LSC K0521	05/30/2024	LSC K0761	05/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0911	05/15/2024	LSC K0918	05/15/2024	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	
4/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO