STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING _____ B. WING _____	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

(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 000	INITIAL COMMENTS Standard Survey: 8/30/22 Census: 106 Sample Size: 22 +2 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights.	F 550		9/22/22

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

Electronically Signed | 09/22/2022

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F 550	Continued From page 1 The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined that the facility failed to maintain dignity during mealtime for a resident who needed assistance with eating. This deficient practice was observed for 1 of 25 residents reviewed, Resident #26 and was evidenced by the following: On 8/8/22 at 12:25 PM, the surveyor observed Resident #26 in bed, eating lunch when she called the Certified Nurse's Aide (CNA) for assistance. The CNA entered the resident's room placing paper trash (removed from protected articles on the tray) ex. Straw paper covering) on top of the resident's meal tray. The surveyor further observed that the CNA was standing over the resident while feeding. The surveyor interviewed the CNA on 8/9/22 at 12:30 PM, and specified that staff should be seated next to the resident while assisting them during feeding time.	F 550	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE •Resident #25 is being provided with appropriate assistance during meal time. •Staff involved feeding resident #25 was reeducated by the Staff Practice Educator on policy and procedure, dignity, sensitivities, and proper way of feeding residents including not standing while feeding. •Performance improvement plan/corrective action regarding the action taken was initiated further action will result in termination. •All residents requiring assistance with feeding during meals were observed for appropriate assistance and not standing while feeding with no further issues or occurrence observed.	

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F 550	Continued From page 2 Review of the Admission record for Resident #26 documented diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] The resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that Resident #26 had a Brief Interview for Mental Status score of [redacted] out of 15, indicating [redacted] The MDS further reflected that the resident required set up help for meals. A review of the facility's policy titled, "Feeding a Patient/Resident" indicated under #6. Sit in chair at eye level with the patient. On 8/16/22 at 2:00 PM, the Administrator, and the Clinical Lead RN were made aware of the surveyor's observation. They both agreed that the CNA should be seated next to the resident when feeding. N.J.A.C. 8:39-4.1(a)12	F 550	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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. •Staff were inserviced by the Staff Practice Educator on feeding policy and procedure, on proper feeding residents needing assistance including not standing while feeding, on dignity, and sensitivity/customer service on 8/16/2022. •All residents requiring assistance with feeding during meals will be assisted and monitored. 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 •Meal audit for residents needing assistance with feeding will be conducted by Unit Managers/designee daily x 2 then monthly x 3 months.	

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F 550	Continued From page 3	F 550	•Findings will be reported to Administrator/Director and will be brought to the Quality Assurance Performance and Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident's call light was readily accessible for a resident who was dependent on staff for care. This deficient practice was identified for 2 of 25 residents reviewed for call bell/light (CBL), Resident #26 and #84, evidenced by the following: 1.) On 8/11/22 at 1:16 PM, the surveyor observed Resident #84's door closed. When the surveyor knocked on the door, the resident stated that she needed the nurse. The surveyor observed that the CBL was hanging toward the floor and out of reach for the resident. The surveyor asked the resident about the CBL. Resident #84 informed the surveyor that they didn't know that there was a CBL to use whenever they needed assistance. The surveyor handed the CBL to the resident. The surveyor observed Resident #84 press the CBL for assistance.	F 558	F558 – Reasonable Accommodations Needs/Preferences HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE •Resident #26 and Resident #84 were checked every shift to ensure call bell are within reached •Quality Assurance round audit conducted to ensure call bell accommodation compliance. •Staff were inserviced immediately by the Staff Practice Educator to ensure that residents call bells are placed within reach at all time. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	9/22/22

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F 558	Continued From page 4 A review of the Admission record for Resident #84 reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted] A review of the resident's significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that Resident #84 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating NJ Exec Order 26.4b1 [redacted]. The MDS further reflected that the resident required extensive to total assistance with one staff assist in most areas of activities of daily living including NJ Exec Order 26.4b1 [redacted] 2.) On 8/11/22 at 1:20 PM, the surveyor observed Resident #26's door closed. When the surveyor knocked on the door, the resident stated that they needed help. The surveyor observed that the CBL was under the pillow beside the side rails. The surveyor asked Resident #26 about the CBL, who then demonstrated the inability to reach it. The surveyor handed the CBL to the resident. The surveyor observed Resident #26 pressed the CBL to request for assistance. At that time, a Licensed Practical Nurse (LPN), assigned to the resident, knocked and entered the resident's room stating, "Why are all the call bell lights on now?" A review of the Admission record for Resident #26 diagnoses which included but were not limited to NJ Exec Order 26.4b1 [redacted]	F 558	SAME DEFICIENT PRACTICE •All Residents have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. •Staff were re-inserviced by the Staff Practice Educator to ensure that all residents call bells are within reach at all time. •Call bell Policy and Procedure was reviewed by the Staff Practice Educator with the staff. 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 •Call Bell audit will be conducted by Unit Mangers/designee daily x 4 weeks and random x 3 months. •Findings will be reported to Administrator/Director of Nursing and will be brought to the Quality Assurance Performance and Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance.	

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F 558	Continued From page 5 and NJ Exec Order 26.4b1 . A review of the resident's quarterly MDS dated NJ Exec Order 26 reflected that Resident #26 had a BIMS score of [redacted] out of 15, indicating NJ Exec Order 26.4b1 [redacted] The MDS further reflected that the resident requires extensive to total assistance with one to two staff assist in most areas of Activities of daily living including NJ Exec Order 26.4b1 [redacted] A review of the facility's policy titled, "Call Lights" documented "Staff will respond to call lights and communication devices promptly." On 8/16/22 at 2:15 PM, the Administrator, and the Clinical Lead RN were made aware of the surveyor's observation. There was no further information provided.	F 558		
F 640 SS=D	NJAC 8:39-4.1(a)11; 31.1(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. (vi) Background (face-sheet) information, if there	F 640		9/22/22

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F 640	Continued From page 6 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 and transmit a Minimum Data Set (MDS) in	F 640	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN	

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F 640	Continued From page 7 accordance with federal guidelines. This deficient practice was identified for 1 of 25 residents reviewed for resident assessment (Resident #1). This deficient practice was evidenced by: On 8/17/22 at 1:30 PM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a 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 within 14 days of the assessment being completed. Resident #1 was observed to have a Discharge MDS with an Assessment Reference Date (ARD) of [NJ Exec Order 26] and was due to be transmitted no later than [NJ Exec Order 26]. The MDS was not transmitted until [NJ Exec Order 26]. According to the latest version of the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2019) page 2-11 " Discharge refers to the date a resident leaves the facility ... The manual revealed on Page 2-17 "A Discharge Assessment - return not anticipated (MDS) must be completed not later than discharge date + 14 days. The assessment must also be transmitted to the QIES ASAP system not later than the MDS completion + 14 days." On 8/18/22 at 9:51 AM, the MDS Coordinator who was responsible for completing and submitting MDS assessments, confirmed that the Discharge MDS was not completed and submitted according to time sensitive federal guidelines.	F 640	AFFECTED BY THE PRACTICE •Resident #1 Discharged MDS was completed and transmitted on [NJ Exec Order 26.b]. •MDS Coordinator was inserviced by the Administrator on timely submission of MDS and Interdisciplinary Team were also inserviced by the Administrator on timely completion of the MDS in accordance with the federal guideline. •All residents MDS reviewed to ensure compliance and if there were any identified not within compliance, it was corrected immediately. •Resident #1 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. 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 discharged MDS are completed and transmitted on a timely manner •All active and discharged residents will be reviewed during the morning report by	

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F 640	Continued From page 8 On 8/18/22 at 12:34 PM, the surveyor informed the Administrator and the Clinical Lead Registered Nurse regarding the above concern. They did not provide any further information. NJAC 8:39-11.2	F 640	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 ASSURANCE PROGRAM WILL BE PUT INTO PLACE •MDS completion and transmission audit for active and discharged residents will completed by the MDS Coordinator/designee 5 day a weeks 4 weeks, then weekly x 4 weeks, and monthly x 3 months. •Any findings will be reported to the Administrator and Director of Nursing and discussed in morning meeting •MDS audits findings will also be discussed during the monthly and quarterly Quality Assurance Performance and Improvement (QAPI) meetings.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by	F 693		9/22/22

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F 693	Continued From page 9 enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the appropriate management of an NJ Exec Order 2 [redacted] This deficient practice was identified for 1 of 5 residents reviewed for NJ Exec O [redacted] (Resident #25), and was evidenced by the following: On 8/9/22 at 1:38 PM, the surveyor observed Resident #25 in bed, in a room where the resident was NJ Exec Order 26.4b1 [redacted] that was turned off at the time. On 8/15/22 at 11:07 AM, the surveyor observed Resident #25 in bed NJ Exec Order 26.4b1 [redacted]. The surveyor noted that the NJ Exec Order 26.4b1 [redacted] The NJ Exec Order 26.4b1 had documented information written stating that it was NJ Exec Order 26.4b1 and started at 4:00 PM at NJ E [redacted] The surveyor noticed that the NJ Exec Order 26	F 693	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE ¿ Resident # 25 was not affected by the deficient practice. NJ Exec Order 26.4b1 setting was immediately corrected to NJ Exec Order 26.4b [redacted] HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All Residents receiving enteral feeding via pump has the potential to be affected by this practice. Residents receiving enteral feeding via pump were audited. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE	

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F 693	Continued From page 10 NJ Exec Order 26.4b1 which originally contained NJ Exec Order 26.4 was almost completed. On 8/15/22 at 11:30 AM, the surveyor noticed the 1st floor Registered Nurse (RN) enter Resident #25's room. The RN was carrying a new NJ Exec Ord[illegible] when entering the resident's room. On 8/15/22 at 11:41 AM, the surveyor entered Resident #25's room and noted that a NJ Exec Order 26.4b1 and attached to the resident's NJ Exec Order 26.4b1. The surveyor noticed that the NJ Exec Order 26.4b1 I had documented information written on it stating that it was NJ Exec Order 26 11:30 AM NJ Exec Order 26.4b1. The surveyor noted that the NJ Exec Order 26.4b1 was now NJ Exec Order 26.4b1 and showing a total NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 On 8/15/22 at 11:54 AM, the surveyor noted that the NJ Exec Order 26.4b1 was still set at NJ Exec Order 26.4b1. The NJ Exec Ord[illegible] was showing that NJ Exec Order 26 and NJ Exec Order 26 was still programmed to NJ Exec Order 26.4b1 On 8/15/22 at 12:34 PM, the surveyor in the presence of 2 other surveyors interviewed the Registered Nurse Practice Educator (NPE) and the RN. Both the NPE and RN agreed that the NJ Exec Order 26.4b1 was not correct and the NPE shut down the NJ Exec Order 26.4b1. The NPE stated that the nurse is responsible for setting the resident's NJ Exec Order 26.4b1. The RN stated that she only came in to change NJ Exec Order 26 when she heard the alarm of NJ Exec Order 26.4b1. The RN stated that she did not touch the NJ Exec Order 2 The surveyor reviewed the medical record for	F 693	THAT THE DEFICIENT PRACTICE WILL NOT RECUR. ¿ Licensed nurses were in serviced by the Nurse Practice Educator on the policy and procedure on Enteral Feeding administration via pump including accurate pump settings on 8/15/2022. Competency will be completed upon hire, annually and as needed. ¿ Licensed nurses were inserviced by the Nurse Practice Educator on Enteral Feeding Policy and Procedure on 8/15/2022. 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 ¿ Random checks will be conducted Unit Managers/designee on all shifts to ensure compliance daily x 2 weeks then weekly x 2 and monthly x 3. ¿ Any discrepancies or trends identified will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance.	

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F 693	Continued From page 11 Resident #25. A review of the resident's Face Sheet (an admission record) reflected that Resident #25 was admitted to the facility with diagnosis that included but were not limited t NJ Exec Order 26.4b1 [redacted] The surveyor reviewed the NJ Exec Order 26.4b1 physician's order entry dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 to administer NJ Exec Order 26.4b1 [redacted] There was another physician's order dated NJ Exec Order 26.4b1 that specified that the NJ Exec Order 26.4b1 [redacted] A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) reflected that the nurses were signing that the start time for the NJ Exec Order 26.4b1 was 4:00 PM and the NJ Exec Order 26.4b1 was stopped at 12 noon the following day. Further review of the MAR reflected that the nurses were documenting on the NJ Exec Order 26.4b1 MAR that the total NJ Exec Order 26.4b1 [redacted] A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score (screen used to assist with identifying a resident's current cognition) of NJ Exec Order 26.4b1 out of 15, indicating NJ Exec Order 26.4b1 [redacted] Further review of the resident's MDS, Section K for Nutritional Status	F 693		

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	315036	A. BUILDING _____ B. WING _____	08/30/2022

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F 693	Continued From page 12	F 693		

reflected that the resident received NJ Exec Order 26.4b1 [redacted]

A review of the resident's weights did not reflect that the resident had a NJ Exec Order 26.4b1 or gain since the need for NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1

A review of the resident's comprehensive care plan dated NJ Exec Order 26 reflected a focus area that the resident required an NJ Exec Order 26.4b1 [redacted] due to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] The goal of the care plan reflected that the resident would tolerate safe NJ Exec Order 26.4b1 [redacted]. The interventions included to NJ Exec O and NJ Exec Or for the resident's NJ Exec Order 26.4b1 per physician's order of NJ Exec Order 26.4b1 [redacted]

A review of the facility's "Enteral Feeding: Administration by Pump" policy and procedure reviewed by the facility on 6/15/22 included, "1. Verify order: Order includes, but is not limited to: 1.5 Flow rate, total volume, and calories per 24 hours."

On 8/16/22 at 2:15 PM, the surveyors met with the Director of Nursing, the NPE and the Administrator who could not give any further information as to why Resident #25's NJ Exec Order 26 [redacted] was set incorrectly.

On 8/18/22 at 11:32 AM, the surveyors interviewed the Registered Dietician (RD) who stated that she has been following Resident #25 since admission. The RD stated that Resident #25 has been "NJ Exec Order 26.4b1". The RD informed

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F 693	Continued From page 13 the surveyors that Resident #25 has had a [NJ Exec Or] [redacted] but the doctor isn't concerned. The RD stated that the NJ Exec Order 26.4b1 [redacted] (ordered rate). The RD explained that the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 [redacted], wouldn't impact the resident as it was only for a short period of time. NJAC 8:39-27.1(a)	F 693		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure a.) that a NJ Exec Order 26.4b1 for a resident who was dependent on NJ Exec Order 26.4b1 via a NJ Exec Order 26.4b1 [redacted] had the proper settings, b.) that the [NJ Exe] [redacted] for a resident who was dependent on NJ Exec Order 26.4b1 via a NJ Exec Order 26.4b1 was connected properly and c.) that a resident who was dependent on NJ Exec Order 26.4b1 [redacted] had a valid physician's order for [NJ Exec] in place.	F 695	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE • Resident # 25 was not adversely affected; [NJ Exec Order 2] [redacted] setting was corrected immediately and there was [NJ Exec Order 26.4b1] [redacted] observed. • The nurse providing care was re-inserviced by the Nurse Practice Educator and Respiratory Therapist on the proper setting of oxygen for trach patients.	9/22/22

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F 695	Continued From page 14 This deficient practice was identified for 1 of 2 residents reviewed with a NJ Exec Order 26.4b1 (Resident #25), and was evidenced by the following: On 8/9/22 at 1:38 PM, the surveyor observed Resident #25 in bed in a room where the resident was connected to NJ Exec via a NJ Exec Order 26.4b1 along with a NJ Exec Order 26.4b1 that was turned off at the time. On 8/15/22 at 11:41 AM, the surveyor entered Resident #25's room and noted the NJ Exec Order 26.4b1 attached to the NJ Exec Order 2 and NJ Exec Order 26.4b1 was set at NJ Ex which corresponded to NJ Exec Order 26.4b1 The resident appeared NJ Exec Order 26.4b1 On 8/15/22 at 11:54 AM, the surveyor along with the Registered Nurse Practice Educator (NPE) observed the setting of the NJ Exec Order 26.4b1 The surveyor along with the NPE reviewed the physician's order for NJ Exec which read, NJ Exec Order 26.4b1 The NPE stated that the NJ Exec Orde was set incorrectly as it should be set for NJ Exec Order 2 The NPE in the presence of the surveyor, evaluated the NJ Exec Order 26.4b1 which was set at NJ The NPE then attempted to adjust the NJ Exe that was on the left side of the resident's bed, when she realized that the NJ Exe was disconnected from the NJ Exe On 8/15/22 at 12:00 PM the NPE checked Resident #25's vitals which were: NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 The NPE stated that the resident's NJ Exec	F 695	• Licensed nurses were inservieced to verify orders for accuracy prior to entering order in the Electronic Medication Administration Record system and sending to pharmacy. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE • All Residents on supplemental oxygen via trach have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. • Licensed nurses were inseviced by the Nurse Staff Educator on the policy and procedure of proper setting of oxygen for residents with trach on 8/15/2022. • Licensed nurses were inservieced to verify orders for accuracy prior to entering order in Electronic Medication Administration Record system and sending to pharmacy. • NJ Exec Order 26.4 setting for resident # 25 was being checked every shift to ensure compliance. If the setting is found to be incorrect, the nurse will adjust the	

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F 695	Continued From page 15 NJ Exec Or should be at least be NJ Exec. The resident did NJ Exec Order 26.4b1 On 8/15/22 at 12:34 PM, the surveyor in the presence of two other surveyors interviewed the NPE along with the Registered Nurse (RN) who was responsible for Resident #25's care. The NPE agreed that the NJ Exec Or r for the NJ Exec Order 26.4b1 was set wrong as well as the NJ Exec Order 26.4b1, which was inaccurately set at NJ Exec Order 2 and most importantly the NJ Exec Order 26.4b1 the NJ Ex to the NJ Exec Order 26.4b1 was disconnected from the NJ Exec Order 26.4b1. The NPE stated that it was the nurses responsibility to check that the settings were correct and that all NJ Exec Order 2 were connected. The RN did not have any additional comments. The surveyor reviewed the medical record for Resident #25. A review of the resident's Face Sheet (an admission record) reflected that Resident #25 was admitted to the facility with diagnoses that included but were not limited NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 physician's order (PO) entry dated NJ Exec Orde documented, NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, leave NJ Exec Order 26.4b1 A review of the nursing entries for the physician's order dated NJ Exec Orde and documented in the NJ Ex.Order 26.4 2022 Electronic Medical Administration Record (eMAR), NJ Exec Order 26.4b1 every shift maintain NJ Exec Order 26.4b1 All nursing entries for NJ Exec Order 26.4b1 to	F 695	correct/prescribed setting. • Respiratory Therapist came on NJ Exec Order 26.4b1 to review the accuracy of the NJ Exec Orde setting; in-service was completed by the Respiratory Therapist on NJ Exec Order 26.4b1 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 • The nurses will check every shift to check for accurate oxygen/trach setting. • The Unit Managers/designee will conduct an audit for accurate settings weekly x 4 weeks and monthly x 3 months. • The Unit Managers/Designee will audit 5 days a week x 1 month and weekly x 3 months, and 3 months thereafter to ensure that orders are verified for accuracy prior to entering order in Electronic Medication Administration Record system and sending to pharmacy. • Any discrepancies of the setting will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance. • Trends and findings from the audits will be reported to the Director of Nursing and will be reviewed by the Quality Assurance and Performance	

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F 695	Continued From page 16 NJ Exec Order 25 were documented as over NJ Exec Ord A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 25 reflected that the resident had a Brief Interview for Mental Status (BIMS) score (screen used to assist with identifying a resident's current cognition) of NJ E out of 15, indicating that the resident had a NJ Exec Order 26.4b1 A further review of the resident's MDS, Section O for Special Treatments and Programs reflected that the resident received NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 . On 8/15/22 at 1:53 PM, the surveyor discussed the above issues with the Registered Clinical Lead Nurse (RNL). The RNL stated that the nurse should be checking the NJ Exe settings and connections for any NJ Exec Order 26.4b1 resident anytime they walk into the room, at minimum once every shift. On 8/16/22 at 2:15 PM, the surveyors met with the Director of Nursing (DON), the NPE and the Licensed Nursing Home Administrator (LNHA) who could not give any further information as to the discrepancies found with the NJ Exe settings for Resident #25. On 8/18/22 at 12:12 PM, the surveyors interviewed the Certified Respiratory Therapist (CRT) who stated that she educates the nursing staff on the care of a NJ Exec Order 26.4b1 resident. The CRT stated that she comes in initially to set up the resident when they are admitted from the hospital.	F 695	Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance.	

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F 695	Continued From page 17	F 695		

The surveyor informed the CRT that the tubing was disconnected from the NJ Exec Order 26.4b1. The CRT responded that the resident was not getting any NJ Exec Order 26.4b1 was disconnected from the NJ Exec Order 26.4b1

2. On 8/16/22 at 8:34 AM, the surveyor observed Resident #25 sitting up in bed wearing a NJ Exec Order 26.4b1 over their NJ Exec Order 26.4b1. The surveyor observed that the NJ Exec Order 26.4b1 was connected to an NJ Exec Order 26.4b1 and that the NJ Exec Order 26.4b1 was set to NJ Exec Order.

On 8/16/22 at 8:35 AM, the surveyor reviewed Resident #25's PO. The surveyor observed that Resident #25 had a PO for NJ Exec Order 26.4b1

On 8/16/22 at 9:10 AM, the surveyor interviewed the RN. The surveyor asked the RN how many NJ Exec Order 26.4b1 Resident #25 should receive. The RN stated that the NJ Exec Order 26.4b1 should be set to NJ The surveyor stated that the PO indicated that the NJ Exec Order 26.4b1 should be set to NJ Exec Order The RN stated that the doctor came this morning and changed the order to NJ Exec Order.

On 8/16/22 at 9:50 AM, the surveyor noted that Resident #25 had a PO for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26 at 15:00 (3 PM). The surveyor also observed that the PO to keep the NJ Exec NJ Exec Order 26 was discontinued on at 8:46 AM.

On 8/16/22 at 12:23 PM, the surveyor interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 18	F 695		

the RN again about the PO and stated that the PO was not active until 3 PM. The RN stated that the Registered Nurse Unit Manager (RN/UM) changed the PO in the electronic medical record (EMR) this morning.

On 8/16/22 at 12:15 PM, the surveyor interviewed the RN/UM. The RN/UM stated that she put the order in at 8:46 AM and that she did not know why it was not active immediately.

On 8/18/22 at 12:12 PM, the surveyor interviewed the CRT. The surveyor stated that there was an interval on 8/16/22 where Resident #25 received NJ Exec Order 26.4b1 to their NJ Exec Order 26.4b1 with no active PO. The CRT stated that there should, "always be an order".

On 8/18/22 at 12:34 PM, the surveyor expressed her concern to the LNHA, RNL, and Infection Preventionist Nurse (IPN).

On 8/22/22 at 11:45 AM the LNHA stated that when a new PO is put into their EMR that it does not become active until the next shift.

Review of the "Oxygen Concentrator" policy and procedure with a facility revision date of 6/15/22, documents, "1. Verify order. 10. Set liter flow per order 11. Attach prescribed oxygen delivery device. Apply oxygen delivery device to the resident."

Review of the Tracheostomy Care Policy and Procedure with a facility revision date of 7/15/21 documents, "2. Verify order."

NJAC 8:39-27.1 (a)

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	315036	A. BUILDING _____ B. WING _____	08/30/2022

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F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to a.) accurately follow facility policy related to the	F 755	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE	9/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 20 wasting of contaminated medication, b.) ensure that physician ordered hold parameters were accurately followed, c.) accurately document the administration of an as needed (prn) controlled substance. This deficient practice was identified for 4 of 24 residents reviewed for medication management (Resident #164, #95, #25 and #161), and was evidenced by the following: 1. On 8/11/22 at 8:42 AM, the surveyor observed the Unit 1 Registered Nurse (RN) prepare medication for administration to Resident #164. During the medication preparation the RN dropped NJ Exec Order 26.4b1 on the contaminated medication cart. The surveyor observed the RN pick up the NJ Exec Order 26.4b1 and throw it into the garbage receptacle attached to the medication cart. The surveyor interviewed the RN after she completed the administration of medication to Resident #164. The RN stated that it's ok to throw the contaminated medication into the garbage attached to the medication cart because, "if it's not a NJ Exec Order 26 it can be put in the garbage." 2. On 8/11/22 at 9:05 AM, the surveyor observed the Unit 3 Licensed Practical Nurse (LPN) prepare medication for administration to Resident #95. During the medication preparation the LPN dropped NJ Exec Order 26.4b1 on the contaminated medication cart. The surveyor observed the LPN pick up the NJ Exec Order 26.4b1 tablet and put it into the clean medication cup that was prepared for administration to Resident #95.	F 755	A. Accurately following facility Policy related to the wasting of contaminated Medication: ¿ 1:1 education provided by the Nurse Practice Educator with the license nurses who conducted Medications Pass for appropriate disposal of medication. ¿ Licensed nurses were educated on the policy and procedure and proper disposal of medications. B. Ensure that physician ordered hold parameters were accurately followed: ¿ Resident#25 was assessed with no adverse effect occurred from this practice. ¿ 1:1 clinical education was provided by the Nurse Practice Educator with the license nurse involved. ¿ Nursing staff were inserviced by the Nurse Practice Educator to follow physician orders for BP medication parameters. ¿ All residents on BP parameters were reviewed with no issues noted. C. Accurately document the administration of an as needed: ¿ Resident#161 MAR was reviewed for proper documentation of PRN controlled substance medication administration. ¿ Nursing staff were inserviced by the Nurse Practice Educator on the proper documentation of controlled substance. ¿ The controlled substance declining sheet and MAR for resident # was reviewed for accuracy.	

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F 755	Continued From page 21 The surveyor interviewed the LPN after she completed the administration of medication to Resident #95. The LPN stated, "If the medicine doesn't fall on the ground, we use the medication. I clean the top of the cart in the morning." Review of the facility "Disposal of Medication Waste" policy with a reviewed date of 6/1/21 explained "Medications for disposal include: Discontinued, expired or contaminated medications not returned to the pharmacy. Medications may be sent with the patient upon discharge, when applicable, donated, where applicable, or disposed of using a contracted medical waste service (e.g., Stericycle). Medications that cannot be returned to the pharmacy, discharged with the patient, or donated will be placed in medication disposal bins. Waste bins will be stored in the medication room or other secure medication storage area not accessible to patients." On 8/11/22 at 11:27 AM, the Licensed Nursing Home Administrator (LNHA) stated that Drug Buster and SteriCycle (receptacles for properly discarding medication) are stored in the medication room and used to dispose of contaminated medications. The LNHA also acknowledged that medications that are contaminated are not to be administered to residents or thrown in the garbage accessible to residents. 3. On 8/9/22 at 1:38 PM, the surveyor observed Resident #25 in bed in a room where the resident was connected to NJ Exec Order 26.4b1 [redacted]	F 755	Residents #164, #95, #25, and #161were not affected by this 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 these practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. A. •Licensed nurses were educated by the Nurse Practice Educator on the policy of procedure of proper disposal medications. • The nurses involved were monitored for appropriately disposed medication and there was no deficient practice observed. B. •Nursing staff were inserviced by the Nurse Practice Educator on following BP parameters. •All residents on BP parameters were reviewed to ensure compliance and there was no issue noted. C.	

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ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

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F 755	Continued From page 22 NJ Exec Order 26.4b1 along with a NJ Exec Order 26.4b1 that was turned off at the time. The surveyor reviewed the medical records belonging to Resident #25. Resident #25 was admitted to the facility with diagnosis that included but were not limited NJ Exec Order 26.4b1 Review of the August 2022 electronic medication administration record (eMAR) presented a physician's order (PO) for NJ Exec Order 26.4b1 tablet via NJ Exec Order 26.4b1 once a day for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 2 Review of the nurses entry documented on the eMAR from NJ Exec Orde to NJ Exec Order 2 revealed 5 days NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 administered despite Resident #25's NJ Exec O measuring NJ Exec Order 26.4b1 On 8/17/22 at 12:00 PM, the surveyor interviewed the Unit 1 Registered Nurse who stated that if the PO for a medication includes a parameter, you need to follow the order and hold the medication if it is not within the specified parameter. On 8/17/22 at 2:00 PM, the LNHA stated that when there is a medication order that includes parameters, the administering medication nurse must evaluate to see if the medication should be administered or held. The LNHA could not provide any further information explaining why	F 755	•Nursing staff were inserviced by the Nurse Practice Educator of the controlled substances management policy and procedure. •All residents on PRN controlled substance were reviewed to ensure compliance and there was no issue noted. 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 •Licensed nurses will be monitored for proper disposal of medications by the Unit Managers/designee weekly x 4 weeks and monthly x 3 months. •The Unit Mangers/designee will audit all residents on medication of BP parameters daily x 1 week, weekly x 4 weeks and monthly x 3 months. •The Unit Mangers/designee will audit all PRN controlled substance orders and documentation on the declining sheet and MAR weekly x 4 weeks and monthly x 3 months. •Findings will be reported to Administrator/Director of Nursing and will be brought to the Quality Assurance and Performance Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING _____ B. WING _____	08/30/2022

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F 755	Continued From page 23	F 755		

there was a discrepancy between the parameter ordered by the physician and the evaluation of the facility nurse as to administering the medication when the NJ Exec Order 26.4b1 than the level set by the PO.

4. On 8/9/22 at 1:22 PM, the surveyor observed Resident #161 behind a closed door to a private room in the facility. Resident #161 was noted in a room that had signage which affirmed that they were being NJ Exec Order 26.4b1. Review of the medical records for Resident #25 revealed there was documentation confirming that the resident was NJ Exec Order 26.4b1

The surveyor reviewed the medical records which belonged to Resident #161. Resident #161 was admitted to the facility with diagnosis that included but were not limited to NJ Exec Order 26.4b1

Review of the August 2022 eMAR presented a PO for NJ Exec Order 26.4b1 (2) tablets every 8 hours as needed (prn) for NJ Exec Order 26.4b1 with a start date of NJ Exec Orde and a discontinue date of NJ Exec Order 26. There was another PO for NJ Exec Order 26.4b1 (1) tablet every 8 hours prn for NJ Exec Order 26.4b1 NJ Exec O with a start date of NJ Exec Orde and a discontinue date of NJ Exec Order 2. There was a third PO for NJ Exec Order 26.4b1 (2) tablets every 4 hours prn for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.

The surveyor reviewed all the nursing entries documented in the Controlled Medication Utilization Record (CMUR), a NJ Exec Order 26 inventory sheet. The CMUR documented all the NJ Exec Order 26.4b1 tablets that were removed from inventory

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F 755	Continued From page 24	F 755		

for the purposes of administering to Resident #161.

The surveyor cross referenced the nursing entries documented in the CMUR with the administration entries documented in the different orders for the NJ Exec Order 26.4b1 in the eMAR, matching up the inventory removal of the for NJ Exec Order 26.4b1 with the documentation of administration to Resident #161. The surveyor found that there were several discrepancies. The surveyor found that the NJ Exec Order 26.4b1 signed by nursing on the CMUR as removed from the inventory had several missing entries by nursing as administered in the eMAR.

The CMUR documented 7 entries dated from NJ Exec Orde to NJ Exec Order 2 confirming (2) tablets of NJ Exec Order 26.4b1 were removed from inventory each time (totals 14 tablets). The eMAR did not document that those 14 tablets of NJ Exec Order 26.4b1 were administered to Resident #161.

The surveyor also found an additional physician's order for NJ Exec Order 26.4b1 (1) tablet every 8 hours prn for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 2 and a discontinue date of NJ Exec Orde. The CMUR documented 2 tablets were removed a total of 3 times while the eMAR documented 1 tablet was administered to Resident #161 on those same dates and times by nursing.

In addition to this order for NJ Exec Order 26.4b1 there was an additional order for NJ Exec Order 26.4b1 (1) tablet every 8 hours prn for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 2 and a discontinue date of NJ Exec Order 2 which documented an administration date of NJ Exec Order 2 and a time of 2338 (11:38 PM)

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F 755	Continued From page 25 which was not entered in the CMUR. On 8/18/22 at 2:00 PM, the LNHA stated that when administering [NJ Exec Order 26.4], the nurse must sign the [NJ Exec Order 26] declining sheet as well as the eMAR documenting administration. No further information was relayed from the facility as to the reason for the discrepancy between the CMUR and eMAR. NJAC 8:39- 29.4(b)2	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		9/22/22

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F 880	Continued From page 26	F 880		

procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its

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F 880	Continued From page 27 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain proper infection control practices identified during 3 of 22 residents observed for infection control breaches, Resident # 95, #25 and #61. This deficient practice was evidenced by the following: 1. On 8/11/22 at 9:05 AM, the surveyor observed the Unit 3 Licensed Practical Nurse (LPN3) prepare for the administration of medication to Resident #95. Prior to the administration of medication, LPN3 removed a device from her pocket, a NJ Exec Order 26.4b1 [redacted]. The surveyor did not observe LPN3 sanitize the NJ Exec Order prior to placing the device on the resident's NJ Exec Order When LPN3 completed the NJ Exec Order 26.4b1, she placed the NJ Exec Order back into her pocket. The surveyor interviewed LPN3 in reference to the sanitation of a multi resident use device. LPN3 stated, "I cleaned the NJ Exec Order in the morning and put it in my pocket." LPN3 then removed the NJ Exec Order from her pocket and cleaned the device with an alcohol swab. Review of the facility "Cleaning and Disinfecting" policy and procedure indicated, "Non-critical items are objects that do not come into contact with mucus membranes, but do come into contact with intact skin (e.g., blood pressure cuff,	F 880	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE •Resident #95, #25 and #61 were not affected by the deficient practice. There is no signs and NJ Exec Order 26.4b1 and no adverse effect occurred. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. •LPN 2 and RN/UM was re - educated by the Infection Preventionist (IP) on proper infection control technique during wound treatment. Treatment competency completed on 8/18/2022. •RN, LPN3 and NPE were re educated by	

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F 880	Continued From page 28 glucose meters, stethoscope, activity supplies, sensory manipulative, craft supplies). These items require cleaning between patient use." Number 5. of the facility "Cleaning and Disinfecting" policy and procedure indicated, "Perform routine disinfection of items used in daily care practices with Environmental Protection Agency (EPA) registered disinfectant." On 8/16/22 at 11:33 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Regional Clinical Lead Registered Nurse who both stated that all multi use devices should be cleaned/sanitized before and after each use with a resident. 2. On 8/16/22 at 8:37 AM, the surveyor observed as the Registered Nurse (RN) and Nurse Practice Educator (NPE) performed NJ Exec Order 26.4b1 [redacted] including NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] on Resident #25. On 8/16/22 at 9:03 AM, the surveyor observed that the RN used a vital signs machine with a NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 to take Resident #25's vital signs including NJ Exec Order 26.4b1 [redacted] On 8/16/22 at 9:05 AM, the surveyor observed that the NPE wheeled the vital signs machine out of Resident #25's room into the hallway and plugged the vital signs machine into an electrical outlet. On 8/16/22 at 9:10 AM, the surveyor interviewed	F 880	Infection Preventionist Nurse on appropriate cleaning/ disinfecting of pulse oximeter/ pressure cuff/ stethoscope before and after use. •Staff were in-serviced by the Infection Preventionist Nurse on cleaning and disinfecting devices used before and after use. •Licensed staff were re - educated on proper infection control technique during wound care treatment by Infection Preventionist Nurse. Treatment competencies will be completed upon hire, annually and as needed. •Competency on wound dressing/aseptic and changing of glove was completed with LPN2 on 8/18/2022 by the Infection Preventionist Nurse. •Root Cause Analysis has been completed based on the imposed DPOC dated 9/22/2022. ALL STAFF RECEIVED THE FOLLOWING DIRECTED IN-SERVICE TRAINING ON 9/16/2022: Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw Provide the training to: Frontline staff	

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F 880	Continued From page 29 the RN and NPE. The surveyor identified that the vital signs machine including [NJ Exec Order 26.4b1] [redacted] were never cleaned or disinfected after it was used on Resident #25 and before it was removed from the room and plugged into the electrical outlet in the hallway. The RN stated that she cleaned the vital signs machine before she used it on Resident #25 and that the NPE brought it out to charge in the hallway because it had a low battery. On 8/16/22 at 11:33 AM, the surveyor expressed her concern to the LNHA, Regional Clinical Lead RN, Infection Control Nurse, and NPE. The Clinical Lead RN stated, that all devices used touching any part of a resident should be cleaned "before and after" use on a resident. The facility policy, "Cleaning and Disinfecting" with a reviewed date of 11/15/21 indicated under the Practice Standards section "5.2 Multi-patient equipment must also be cleaned/ disinfected after patient use." 3. On 8/8/22 at 12:13 PM, during the initial tour, Resident #61 was observed in a right side-lying position in bed, with eyes closed. A review of Resident #61's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to, [NJ Exec Order 26.4b1] [redacted] A review of the Significant Change in Status in the Minimum Data Set, an assessment tool used to facilitate care management dated [NJ Exec Order 26] [redacted], indicated a Brief Interview for Mental Status	F 880	CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Clean Hands https://youtu.be/xmYMUly7qiE Provide the training to: Frontline staff Nursing Home Infection Preventionist Training Course Module 11A - Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/lO8l8l4/ Provide the training to: All nursing staff Nursing Home Infection Preventionist Training Course Module 10C - Infection Prevention during Wound Care https://www.train.org/cdctrain/course/1081811/ Provide the training to: All nursing staff, including Nurse Practice Educator 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 •Unit managers/ IP/ designee will conduct random monitoring on all shifts to ensure appropriate infection control technique is practiced x 1 month, then weekly x 2 and monthly x 3. •Unit managers/ IP/ designee will conduct random monitoring on cleaning and disinfecting devices used before and after	

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F 880	Continued From page 30 scored at [redacted] of 15, which indicated that the resident had NJ Exec Order 26.4b1 The surveyor reviewed the NJ Exec Order 26.4b1 Physician Order Summary, which reflected a Physician's order (PO) to NJ Exec Order 26.4b1 , apply NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1, pack NJ Exec Order 26.4b1 with NJ Exec Or [redacted], and apply the NJ Exec Order 26.4b every day and evening shift for NJ Exec Order 26.4b1 . The same PO was also noted on the NJ Exec Order 26.4b1 electronic Treatment Administration Record (eTAR). On 8/18/22 at 11:15 AM, the surveyor observed the Unit 2 Licensed Practical Nurse (LPN2) perform a NJ Exec Order 26.4b1 to a NJ Exec Order 26.4b1 [redacted] of Resident #61. LPN2 was observed assisted by the Registered Nurse/Unit Manager (RN/UM) in the positioning of the resident during the treatment. Upon entering the resident's room, the surveyor observed LPN2 and RN/UM introduce themselves and inform the resident of the NJ Exec Order [redacted]. LPN2 closed the curtain for privacy. The surveyor observed LPN2 and RN/UM putting on gloves without washing or sanitizing their hands. LPN2 and and RN/UM proceeded to position Resident #61 to the right side in bed. The surveyor observed during that LPN2 wore the same contaminated gloves that she wore to reposition the resident during the treatment process. LPN2 wore the same contaminated gloves to cleanse the NJ Exec Order 26.4b1 [redacted]	F 880	use x 1 month, then weekly x 2 and monthly x 3. •Findings will be reviewed by the Quality Assurance Performance Improvement (QAPI) Team during the monthly and quarterly meetings to ensure compliance.	

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ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

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F 880	Continued From page 31	F 880		

NJ Exec Order 26.4b1

On 8/18/22 at 11:44 AM, the surveyor interviewed the LPN2 and RN/UM about concerns observed during the NJ Exec Order 26.4b1. They both acknowledged that hand hygiene should have been initiated prior to applying gloves and positioning the resident in bed. They further acknowledged that the LPN2 should have removed her gloves after cleansing the NJ Exec Order [redacted] washed her hands, and applied new pair of gloves before proceeding to apply the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with NJ Exec Or[redacted]

On 8/18/22 at 11:50 AM, the surveyor reviewed the facility's policy and procedure titled 13.4 Wound Cleansing in the presence of the LPN2 and RN/UM. Under Process: 11. "Remove the soiled gloves and place in a plastic disposal bag. 12. Cleanse your hands. Apply clean gloves. 13. Apply the treatment/dressing as ordered."

On 8/18/22 at 12:36 PM, the surveyor informed the LNHA, Regional Clinical Lead RN, and Infection Control Nurse regarding the above concern. The Regional Clinical Lead RN stated that LPN2 and RN/UM should have initiated hand hygiene (washed their hands) prior to applying gloves and positioning the resident in bed. The Regional Clinical Lead RN further stated that LPN2 should have removed the gloves after cleansing the NJ Exec Order 26.4b1, washed her hands, and applied a new pair of gloves before proceeding to apply the NJ Exec Order 26.4b1 and pack the NJ Exec Order 26.4b1

NJAC 8:39-19.4 (a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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	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 THOSE	9/22/22

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

Electronically Signed | 09/22/22

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 Assembly of the State of New Jersey: C.30:13-18 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.	S 560	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE All residents have the potential to be 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. • Director of Nursing (DON)/Administrator and staffing coordinator were re educated on NJ staffing mandate. • Center will continue recruiting functions, which drive various forms of media to increase the number of applicants • Forms external partnerships with schools to training Students and transitioning them into Certified Nursing Aide (C.N.A) . ; and Converts temporary C.N.As into permanent C.N.As • Weekly Staffing calls with regional support team HOW THE FACILITY WILL MONITOR ITS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060706	A. BUILDING: _____ B. WING _____	08/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 (3) All computations shall be based on the 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 the 2 week period of 7/24/22 to 8/6/22 revealed the following: The facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -07/24/22 had 11 CNAs for 113 residents on the day shift, required 14 CNAs. -07/25/22 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. -07/26/22 had 13 CNAs for 113 residents on the day shift, required 14 CNAs. -07/27/22 had 13 CNAs for 113 residents on the day shift, required 14 CNAs. -07/28/22 had 13 CNAs for 114 residents on the day shift, required 14 CNAs. -07/29/22 had 12 CNAs for 114 residents on the day shift, required 14 CNAs. -07/30/22 had 12 CNAs for 114 residents on the day shift, required 14 CNAs. -07/31/22 had 12 CNAs for 113 residents on the day shift, required 14 CNAs. -08/01/22 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. -08/02/22 had 13 CNAs for 110 residents on the day shift, required 14 CNAs.	S 560	CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE • The Director of Nursing, staffing coordinator and Human Resource (HR) coordinator/designee will maintain a listing of current recruiting efforts, and document 3 days a week the results of these efforts. • The Administrator will audit these efforts twice weekly x 4 weeks, weekly x2 weeks then monthly x 2 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
	060706	A. BUILDING: _____ B. WING _____	08/30/2022

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S 560	Continued From page 3 -08/03/22 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. -08/04/22 had 13 CNAs for 109 residents on the day shift, required 14 CNAs. The facility was not in compliance with the State of New Jersey minimum staffing requirements during 12 of 14 days during the day shift period reviewed from 7/24/22 through 8/6/22. On 8/10/22 at 9:44 AM, the surveyor discussed the staffing ratio concerns with the Administrator. The Administrator replied that it's been difficult staffing. She 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315036 Y1	A. Building B. Wing Y2	11/10/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

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 F0550	Correction	ID Prefix F0558	Correction	ID Prefix F0640	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(e)(3)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	09/22/2022	LSC	09/22/2022	LSC	09/22/2022
ID Prefix F0693	Correction	ID Prefix F0695	Correction	ID Prefix F0755	Correction
Reg. # 483.25(g)(4)(5)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	09/22/2022	LSC	09/22/2022	LSC	09/22/2022
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/22/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/30/2022	☐ 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
060706 Y1	A. Building B. Wing Y2	11/10/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

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 09/22/2022	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	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
8/30/2022

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

EVENT ID: XWHN12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	**25 E LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

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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 08/23/22 and 08/24/22,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 The facility is a 2-story building that was built in 60's, It is composed of Type I fire resistant construction in ACO. The building was observed to be Type II OOO unprotected beam/deck/truss. The facility is divided into 11 smoke zones. The Maintenance Director and Regional Plant Operations Director, did not provide what the generator percentage was to the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 122 certified beds. At the time of the survey the census was 110.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101	K 222		9/22/22

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

Electronically Signed | 09/22/2022

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 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 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	K 222		

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K 222	Continued From page 2 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 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 interview, in the presence of Maintenance Director, Plant Operations Director on 08/23/22, it was determined that the facility failed to provide exit doors 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 for 2 of 2 sets of exterior exit/egress doors observed. This deficient practice was identified for 2 of 2 sets of doors and was evidenced as follows: At 11:08 AM, the Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director observed two sets of glass	K 222	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE • The glass sliding doors were repaired on 9/8/2022 for the doors to be readily accessible and free of all obstructions in case of fire or other emergencies in accordance with the requirements of NFPA. • No residents were affected by this practice. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	

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K 222	Continued From page 3 sliding doors located at the front entrance of the facility, the interior set of sliding glass doors indicated with a red strip sign approximately 3" x 30" that "IN AN EMERGENCY PUSH TO OPEN". The doors were observed to not have the ability to push to open in the event of an emergency. The current evacuation plan indicated that the front doors were designated an exit/egress route. The Maintenance Director and Regional Plant Operation Director confirmed the findings during the observations. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	SAME DEFICIENT PRACTICE • All residents have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR • Maintenance staff re-inserviced to check the functionality of emergency doors according the preventive maintenance guideline. • The sliding doors were repaired with no further issues observed. 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 • Maintenance Director/designee will check sliding doors for functionality daily x 4 weeks and weekly x 12 months to ensure compliance. • The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 232 SS=E	Aisle, Corridor, or Ramp Width CFR(s): NFPA 101	K 232		10/14/22

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K 232	Continued From page 4 Aisle, Corridor or Ramp Width 2012 EXISTING The width of aisles or corridors (clear or unobstructed) serving as exit access shall be at least 4 feet and maintained to provide the convenient removal of nonambulatory patients on stretchers, except as modified by 19.2.3.4, exceptions 1-5. 19.2.3.4, 19.2.3.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/23/22 in the presence of the Maintenance Director, Regional Plant Operations Director, it was determined that the facility failed to provide a corridor which was at least four feet wide. This deficient practice was evidenced for 1 of 30 resident rooms observed by the following: At 11:21 AM the Surveyor, Surveyor 2, Maintenance Director and Plant Operations Director observed that resident room 207, located inside the left-side of the nurse station, did not have a four foot pathway to the corridor. The distance from the pink wall to the counter was approximately 36" and from the chair to the wall was approximately 24" The Maintenance Director confirmed the findings during the observation. NJAC 8:39-31.1(c)	K 232	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE • Resident room #200 not #207 (based on the description and observation) located inside the left-side of the nurse station will have a four-foot pathway to the corridor. • This room (room #200) is currently vacant. • All resident rooms exit access/corridor were checked to be at least four feet wide. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL	

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K 232	Continued From page 5	K 232	NOT RECUR • Facility has contracted a professional service to remove part of the nursing station to provide a corridor which is at least four feet wide to and from the pathway of room 200. • The removal part of the nursing station to provide at least four feet wide corridor was completed by October 14, 2022. 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 • Resident room #200 not #207 (based on the description and observation) located inside the left-side of the nurse station is adjusted to have a four-foot pathway/width to the corridor. • The resident room# 200 corridor/width was inspected after completion and is at least four feet wide. • Maintenance Director will perform visual check weekly x 1 month and monthly x 3 months to ensure the resident room #200 corridor sustains at least for feet wide. • The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up	

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K 232	Continued From page 6	K 232	accordingly.	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 08/23/22, in the presence of the Maintenance Director and Plant Operations Director, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affects 4 of 4 units and was evidenced by the following: 1) At approximately 11:00 AM, the unit-1 exit/egress area outside the facility was provided with 2-sources of lighting. The Maintenance Director indicated that the Light fixtures were switched, he then activated the switch and the light was powered on. 2) At approximately 11:25 AM, the unit-2 exit/egress area outside the facility was provided with 2-sources of lighting. The Maintenance Director indicated that the Light fixtures were switched, he then activated the switch and the light was powered on. 3) At approximately 11:51 AM, the unit-3	K 281	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE "On 8/24/2022, the facility installed emergency illumination lightings along the exit/means of egress by of the outside area. "All exit doors have emergency illumination lightings. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR	9/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	**25 E LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

(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 281	Continued From page 7 exit/egress area outside the facility was provided with 2-sources of lighting. The Maintenance Director indicated that the Light fixtures were switched, he then activated the switch and the light was powered on. 4) At approximately 11:51 AM, the unit-4 exit/egress area outside the facility was provided with 2-sources of lighting. The Maintenance Director indicated that the Light fixtures were switched, he then activated the switch and the light was powered on. The findings were verified by the Maintenance and Regional Plant Operations Directors at the time of the observation's. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	"The facility staff conducted round on the outside facility exit/means of egress areas and there were no other identified issues. "Maintenance staff were inserviced to check all identified locations to ensure that lights are in proper working conditions. 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 "Maintenance Director will perform visual check audits of the identified locations 5 days a weekly x 2 months and weekly x 1 monthly to ensure proper lighting in all exit/egress of the facility outside areas. "The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING 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	K 293		9/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

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K 293	Continued From page 8 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 interview on 08/23/22, in the presence of the Maintenance Director and Regional Plant Operations Director, the facility failed to provide signs with a directional indicator showing the direction of travel, in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. The deficient practice was identified for 1 of 18 exit signs observed and was evidenced by the following: At 12:28 PM, the surveyor in the presence of the Maintenance Director and Regional Plant Operations Director observed in the Smoking patio that inside the gated fence there was no sign indicating the direction of travel to the nearest exit to the public way. The surveyor observed a sign on the outside of the gate indicating " Emergency Exit Only". The findings was verified by the Maintenance Director and Regional Plant Operations Director at the time of the observation. NFPA 101, 2012 Edition, Section 19.2.10, 19.2.10.1, 7.10.1.2, 7.10.2, 7.10.2.1. NJAC 8:39-31.2(e)	K 293	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE "A sign indicating the direction of travel to the nearest exit was place by the patio gated fence area. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR "The Maintenance Director and Administrator completed a walkthrough to ensure appropriate signage is posted throughout exterior of the building. "Maintenance staff were inserviced to check all identified locations to ensure that signage is placed to identify the direction of an exit path throughout the interior and exterior of the building. HOW THE FACILITY WILL MONITOR	

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	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 293	Continued From page 9	K 293	ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE "Maintenance director/designee will perform audits of the identified locations and any exit paths areas weekly x 3 months to ensure proper signage are placed on the path of exit areas. "The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		10/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

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K 321	Continued From page 10 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was identified in 2 of 2 Hazardous storage rooms as evidenced by the following: 1) At 12:09 PM, the Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director observed in the boiler room that the Medical Records room contained 25 plus combustible cardboard boxes and the door did not have an auto closing device installed on the door. The door was observed to not have any fire resistant endurance rating. 2) At 12:12 PM, the Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director observed that the door to the	K 321	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE • An auto closing device was installed immediately on the door of the Medical Records room. • An auto closing device was installed in the boiler room. • Current doors in Medical records and in boiler room will be replace by a smoke and fire resistant endurance rating. • All storage doors were checked for compliance with no issues. 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. WHAT MEASURES WILL BE PUT INTO	

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	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 11 Boiler room door was propped open and not self-closing. The door was observed to not have any fire resistant endurance rating. The Maintenance Director confirmed the finding's during the observations. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR • Current doors in Medical records and in boiler room will be replace by a smoke and fire resistant endurance rating. • The Maintenance staff were re-educated on the Preventative Maintenance Program and to ensure that all storage rooms have auto closing device installed and are fore resistant. • All storage areas were checked to ensure compliance with auto closing and to have fire barrier. • Facility has contracted a professional service to install s smoke and fire resistant doors in both the Medical Records and boiler rooms. • The replacement of the doors is estimated to be completed October 5, 2022. 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 • All Hazardous areas were checked and is in compliance. • Maintenance Director will inspect all hazardous area weekly x 4 weeks and monthly x 3 months. • The findings will be submitted to the Administrator and reported to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 12	K 321	Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly. • The facility will inspect the Medical Records and boiler room doors to ensure compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interviews on 08/23/22, it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7,	K 353	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE "The ceiling that were not smoke	9/22/22

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	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 13 NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. This deficient practice was evidenced for 9 of 30 areas observed by the following: 1. Floor 2 electrical room oversized ceiling cuts around 8-Electrical cables. 2. Roof access outside resident room 410 was missing an approximately 3' x 3' wall board. 3.Floor 2 Ice Machine room opening in the ceiling approximately 2' X 8". 4.Unit 2 soiled utility room 1/2 opening around the fire sprinkler head. 5.Resident Room 201 fire sprinkler escutcheon plate not in place. 6. Receptionist office closet opening in the ceiling around phone lines. 7. Floor 1 Central supply room 4 openings in the drop ceiling tiles. 8. Dietary Manager office approximately 1" opening around the fire sprinkler head. 9. unit 1 exit stairwell janitors closet missing eschutcheon plate. The Maintenance Director confirmed the above findings during the observations. NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353	resistance and fire rated identified in the statement of deficiencies (1. Floor 2 electrical room oversized ceiling cuts around 8-Electrical cables. 2. Roof access outside resident room 410 was missing an approximately 3' x 3' wall board. 3.Floor 2 Ice Machine room opening in the ceiling approximately 2' X 8". 4.Unit 2 soiled utility room 1/2 opening around the fire sprinkler head. 5.Resident Room 201 fire sprinkler escutcheon plate not in place. 6. Receptionist office closet opening in the, ceiling around phone lines. 7. Floor 1 Central supply room 4 openings in the drop ceiling tiles. 8. Dietary Manager office approximately 1" opening around the fire sprinkler head. 9. unit 1 exit stairwell janitors closet missing eschutcheon plate) were all repaired by 8/30/2022. "The facility staff conducted round to ensure ceiling meets the life safety code requirement and if there were findings it was repaired immediately. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR	

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	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 14	K 353	"All ceilings were checked for smoke resistance and fire rated compliance. "The Maintenance staff were re-educated on the Preventative Maintenance Program and to ensure that all ceiling to be smoke resistance and fire rated. 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 "Maintenance Director will perform audits of ceiling that are not smoke resistance and fire rated weekly x 3 months. "The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 363 SS=E	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 smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible	K 363		9/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 15 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 and interview on 8/23/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in	K 363	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE "All resident room doors identified in the statement of deficiencies (Resident Room #102 the door would not latch due to a hardware malfunction. Resident Room	

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	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 16 place. This deficient practice was identified in 6 of 30 resident room doors observed and was evidenced by the following: On 08/23/22 during the building tour from 9:15 AM to 3:00 PM, the surveyor, surveyor 2, Maintenance Director, and Regional Plant Operations Director toured the facility and observed the following: Resident Room #102 the door would not latch due to a hardware malfunction. Resident Room #201 the door would not latch due to the door hitting the frame. Resident Room #213, the door would not latch due to the door hitting the frame. Resident Room #214 the door would not latch due to the door hitting the frame. Resident Room #301 the door would not latch due to the door hitting the frame. Resident Room #412 the door would not latch due to the door hitting the frame. At the time of observations, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director, who confirmed the above findings. The Administrator were informed of the finding's at the Life Safety Code Exit Conference on 08/24/22. 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	#201 the door would not latch due to the door hitting the frame. Resident Room #213, the door would not latch due to the door hitting the frame. Resident Room #214 the door would not latch due to the door hitting the frame. Resident Room #301 the door would not latch due to the door hitting the frame. Resident Room #412 the door would not latch due to the door hitting the frame) were repaired and were able to properly close and latch in order to properly confine fire and smoke by 9/2/2022. " All resident room doors and other doors in the facility were checked for appropriate door closure and that it□s latching for fire and smoke confinement. Any identified room doors if there were any were corrected. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR "All resident room doors and facility wide room doors were inspected and corrected. "Maintenance staff were inserviced to check all residents room doors and facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	**25 E LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

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K 363	Continued From page 17	K 363	wide doors as part of the routine Preventative Maintenance guideline. 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 "Maintenance Director will perform audits of the of all resident room doors and other area in the facility doors weekly x 3 months to properly confine fire and smoke. "The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 531 SS=E	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with	K 531		10/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

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(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 531	Continued From page 18 Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 08/24/22, in the presence of Maintenance Director, Regional Plant Operations Director and Surveyor 2, it was determined that the facility failed to test and inspect the elevator annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division. This deficient practice was evidenced by the following: A review of the facility's elevator inspection certificate, revealed that 2 of 2 hydraulic elevator devices marked: Temporary Certificate of Occupancy/Compliance for both device's #1 and #2. The annual inspection date of 01/26/21 and the current date of 08/24/22 indicated that the annual inspection date was almost 7-months past due. In an interview, at 11:30 AM, the facility's Maintenance Director stated he will communicate with their contracted elevator vendor and DCA to schedule an inspection as soon as possible. The Administrator was informed of this issue at the Life Safety Code exit conference on 08/24/22. NJAC 8:39-31.2(e)	K 531	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE • The elevator inspection by the New Jersey Department of Community Affairs Division of Code and Standards Elevator Safety Division was scheduled for August 29, 2022. • The Department of Community Affairs were contacted several times throughout 2022 as they indicated that the inspector retired and that they will schedule as soon as they can. • The August 29, 2022 inspection was again cancelled due to the inspector not able to make it and is now scheduled for October 6, 2022. • The Elevator company conducts monthly inspection of the elevator with no issues reported. • The facility will be in compliance with elevator inspection by the New Jersey Department of Community Affairs Division of Code and Standards Elevator Safety Division by 10/15/2022. • The elevator inspection by the New Jersey Department of Community Affairs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

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ARBOR GLEN CENTER	**25 E LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

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K 531	Continued From page 19	K 531	Division of Code and Standards Elevator Safety Division was completed October 14, 2022. • • Residents were not affected by this 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR • Facility will review and update elevator inspection annually conducted by the New Jersey Department of Community Affairs Division of Code and Standards Elevator Safety Division • Maintenance was inserviced to ensure compliance with elevator inspection, and update Administrator of any noncompliance. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE	

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	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

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ARBOR GLEN CENTER	**25 E LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

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K 531	Continued From page 20	K 531	PROGRAM WILL BE PUT INTO PLACE • Maintenance Director/designee will conduct audit monthly x 9 months of all inspections including elevator inspections to ensure compliance and compliance issues will be reported to the Administrator and Regional Maintenance. • The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where	K 741		9/22/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING **01** B. WING _____	**08/30/2022**

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K 741	Continued From page 21 smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/23/22, in the presence of the Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director, the facility failed to maintain smoking areas and in accordance with the requirement of NFPA 101, 2012 Edition, Section 19.7.4. The practice of dumping cigarette buts and ash into trashcans with other combustibles, increases the risk of fire to facility occupants. This deficient practice was evidenced for 1 of 1 smoking areas observed and was evidenced by the following: At 11:48 AM, Surveyor, Surveyor 2, Maintenance Director and Regional Plant Operations Director observed the trash/garbage container with cups, gloves, ciggerate butts and ash mixed together. The container was not an approved astray for disposal of ciggerate butts. There were no approved self-closing covered metal container's for the disposal of cigarette butts and ashes. The finding was verified by the Maintenance Director at the time of the observation. NJAC 8:39-31.2(e)	K 741	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE •Trash receptacle was emptied and was not near the smoking area. •Signed placed by trash receptacle in the patio area not to place cigarette buts and ash in the trashcans. •Staff and residents were re-inserviced on the smoking policy and procedure and to only place cigarette buts and ash in a ashtrays of noncombustible which is in all the designated smoking area. •Residents that smoke also were re-educated on the smoking policy and procedure. 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. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ARBOR GLEN CENTER	**25 E LINDSLEY ROAD** **CEDAR GROVE, NJ 07009**

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K 741	Continued From page 22	K 741	CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR •Staff re-inserviced on the smoking policy and procedure including the location and time of the smoking. •Residents that smoke also were re-educated on the smoking policy and procedure. •Housekeeping and maintenance staff inserviced to conduct rounds daily and check all trashcan for noncompliance and report immediately. 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 •Maintenance Director/designee will conduct rounds/audit to check the presence of cigarette buts/ash daily x 4 weeks and weekly x 3 months to ensure compliance. •The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101	K 911		9/22/22

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K 911	Continued From page 23 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) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/23/22, it was determined that the facility did not maintain the required clearance around electrical panels, electrical equipment and controls in accordance with NFPA 101, 2012 LSC Edition, Section 19.5.1, 19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26. This deficient practice of not ensuring 36" in-front of the electrical panels will prevent staff and emergency personnel from disconnecting the electrical power quickly in the event of an emergency. In addition, cardboard storage boxes and paper stored in front of electrical equipment may provide an ignition source and pose a potential fire risk. The deficient practice was observed in 2 of 6 electrical rooms observed, and was evidenced by the following: 1) At 11:28 AM, the surveyor observed in the electrical room by resident room 203 that a soiled utility cart was blocking the ability to access the electrical panel in the event of an emergency. 2) At 12:45 PM, the surveyor observed in the boiler room that boxes on the floor were blocking the ability to access the roof chiller electrical shutoff panel in the event of an emergency.	K 911	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE "The soiled utility cart was removed immediately. "Housekeeping staff were inserviced not to place the soiled utility cart in front of the electrical panel. "The boxes in the boiler room floor were removed for easy access to the roof chiller electrical shutoff panel. "Maintenance staff were inserviced the importance of 36 guikeline around the roof chiller electrical shutoff panel and any other electrical panels. "All electrical panels in the facility were checked for 36 clearance and there were no issues found. 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	

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K 911	Continued From page 24 The observation's were confirmed by the Maintenance Director and Regional Plant Operations Director, during the tour of the electrical rooms in the facility. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	affected by this practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR "Housekeeping staff were inserviced not place the soiled utility cart in front of the electrical panel. "The boxes in the boiler room floor were removed for easy access to the roof chiller electrical shutoff panel. "Maintenance staff were inserviced the importance of not placing any items in front of the roof chiller electrical shutoff panel and any other electrical panels. 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 "Maintenance Director/designee will conduct rounds/audit to check 36 clearance of electrical panels/shutoff panels daily x 4 weeks and weekly x 3 months to ensure compliance. "The findings will be submitted to the Administrator and reported to the Quality Assurance and Performance Improvement Committee monthly and quarterly. Administrator/designee will address finding concerns and follow-up accordingly.	

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
315036 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/10/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

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	09/22/2022	LSC K0232	10/14/2022	LSC K0281	09/22/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	09/22/2022	LSC K0321	10/05/2022	LSC K0353	09/22/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	09/22/2022	LSC K0531	10/14/2022	LSC K0741	09/22/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	09/22/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/30/2022	☐ YES ☐ NO