STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. BUILDING _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	**536 RIDGE 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 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 08/14/23 - 08/17/23 Survey Census: 170 Sample Size: 39 Supplemental Residents: 0 No deficiencies were issued related to Intakes: Complaint #NJ146255, NJ150874, NJ152557, NJ151495 and NJ151678.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact	F 561		9/7/23

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

Electronically Signed | 09/05/2023

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F 561	Continued From page 1 with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one out of 39 sampled residents (Resident (R) 117). The facility staff failed to promote choices regarding R117 being able to stay in Ex.Orde room instead of going to the activity room. R117 was dissatisfied with having to go to the activity room instead of staying in Ex.Orde room. Findings include: Review of R117's undated "Face Sheet" under the "Profile" tab in the electronic medical record (EMR) revealed R117 was admitted to the facility on Ex Order 26. 4B1. Review of the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/20/23 in the EMR under the "MDS" tab, revealed a Brief Interview for Mental Status (BIMS) score of Ex Order out of 15, which indicated resident's cognition was Ex Order 26. 4B1. The MDS indicated that it was somewhat important for R117 to be able to choose an important activity. R117 required Ex Order 26. 4B1 with Ex Order 26. 4B1 on unit of one person. Review of R177's "Care Plan" dated 02/16/23, in	F 561	Deficiency: F561 Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Staff member was educated on resident's rights. We re-assessed Resident R117's activity preferences. 2. 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 deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All residents' activity	

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F 561	Continued From page 2 the EMR under the "Care Plan" tab revealed, " When [R117] choose not to participate in organized activities, the resident prefers to watches television, talks with [redacted] roommate talks on the telephone, magazine browses for [redacted]." Observation on 08/14/23 at 10:50 AM, Licensed Practical Nurse (LPN)7 was taking R117 to the activity room in *Ex Order 26. 4B1*. At 10:55 AM, R117 put [redacted] hands on both *Ex Order 26. 4B1* wheels and stopped the *Ex Order 26. 4B1* from rolling. R117 was telling LPN7 that [redacted] wanted to go back to [redacted] room. LPN7 removed R117's [redacted] from the [redacted] and stated, *Ex Order 26. 4B1* [redacted] LPN7 began again [redacted] R117 up the hallway to the activity room. When R117 arrived in the activity room, LPN 7 placed *Ex Order 26. 4B1* up next to the activity room table. Immediately R117 began pushing back from the table stating *Ex Order 26. 4B1* [redacted] At 11:05 AM, R117 began self-propelling the *Ex Order 26. 4B1* out of the activity room. [redacted] The Activity personnel asked [redacted] to stay and R117 replied "No." Certified Nurse Aide (CNA) 10 took R117 back to *Ex Order 26. 4B1*. During an interview at 12:30 PM, LPN 7 stated, *Ex Order 26. 4B1* [redacted] During an interview at 12:40 PM, CNA 10 stated, *Ex Order 26. 4B1* [redacted] During an interview on 08/17/23 at 10:30 AM, the regional clinical nurse and Director of Nursing (DON) was notified of the above observation. The	F 561	preferences will be reviewed quarterly and as preferences change to assure each resident makes choices for his or her life in the facility that are significant to the resident. Licensed and Certified Nursing staff were educated on reporting to the nurse when residents refuse to partake in activities to allow for accurate documentation of the refusal and to determine if there has been a change in their activity preference. 4. 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: DON/Designee will interview four residents monthly for the next two quarters to ensure staff are meeting resident activity preferences. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

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F 561	Continued From page 3 DON stated, "we would like to engage them in activities, if at all possible, to divert their minds on something else but if they state they do not want to do something then we will find alternative ways to achieve this so they don't fall if they get up." NJAC 8:39-4.1(a)32	F 561		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623		9/7/23

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F 623	Continued From page 4 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623		

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F 623	Continued From page 5 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to notify the Ombudsman of the transfer to the hospital for one of four residents (Resident (R) 8) reviewed for hospital transfers, out of a total sample of 39 residents. Findings include: Review of the facility's policy titled, "Nursing Home Monthly Ombudsman Notification Policy," dated 01/02/23, revealed, "Policy Statement: This	F 623	POC F 623 notice requirements Resident #8 was not affected by this deficient practice, although all residents have the potential to be affected. The resident was added to the discharge list for the ombudsman. The Nursing Supervisors and Unit Managers were reeducated regarding inputting all hospital transfers into the ADT section of PCC.	

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F 623	Continued From page 6 policy outlines the monthly notification process for engaging the New Jersey (NJ) Ombudsman Program in nursing homes. This policy aims to establish a systematic procedure for notifying the NJ Ombudsman Program about resident discharges monthly to the state ... Notification Submission: ... b. The compiled report shall include information such as the resident's name, date, type, and location of the transfer." Review of R8's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R8 was admitted to the facility on [redacted] and readmitted on [redacted]. Review of R8's EMR "Progress Notes," located under the "Notes" tab, revealed a "general note" dated 07/25/23 " ...Resident noted with [redacted].Call made out to [name] with full report given. New order to send patient to [redacted] ..." Review of the facility report "Admission/Discharge To/From Report, ... Discharges 7/1/2023 to 7/31/2023 (sic) dated 01/02/23, revealed, R8 was not listed on the report. In an interview on 08/17/23 at 12:00 PM, the Social Services Director (SSD) stated, "the resident is not listed on the report, I'm not sure why." NJAC 8:39-5.1(a)	F 623	The Director of Admissions compiles the census every morning, as well as on Mondays for the prior weekend. In addition, she was directed to check every day to assure that every hospital transfer was indeed recorded in PCC and documented appropriately. At the beginning of every month, the Director of Social Services was educated to run the DC report from PCC and check thoroughly with the Director of Admissions for any omissions prior to sending to the Ombudsman's office. The Director of Social Services will randomly check 5 hospitalized residents every month for 3 months to assure compliance and will present those findings to the Administrator at the QAPI meeting which is held quarterly.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		9/7/23

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F 641	Continued From page 7 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review, the facility failed to ensure that Minimum Data Set (MDS) assessments accurately reflected the residents' medication status for two of two (Resident (R) 71 and R89) in a total sample of 39 residents. Findings include: 1. Review of the facility's policy titled, "MDS Completion and Submission Timeframes," dated 1/2023 revealed, "Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes." The policy failed to address the accuracy of the assessment. Review of R71's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab revealed R71 was admitted to the facility on Ex Order 26. 4B1 and with diagnoses which included Ex Order 26. 4B1 [redacted] Review of the EMR Admission "MDS" with an Assessment Reference Date (ARD) of 07/08/23, indicated R71 used [redacted] since admission. Review of R71's "physician orders" found in the EMR under the "Orders" tab failed to reveal any orders for [redacted]. During an interview on 08/16/23 at 4:50 PM, the	F 641	F 641 Accuracy of Assessments 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: MDS section was immediately modified for both Resident R71 and Resident R89. 2. 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 deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/designee will educate MDSC to follow RAI guidelines to complete MDS section. 4. 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: MDSC will conduct monthly audits x2,	

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F 641	Continued From page 8 MDS Coordinator (MDSC) stated Ex Order 26. 4B1 [redacted]. I need to correct that." 2. Review of R89's undated "Admission Record" located in the "Profile" tab of the EMR revealed R89 was admitted to the facility on Ex Order 26. 4B1 with a diagnosis of Ex Order 26. 4B1. Review of R89's "Physician Orders" located in the "Orders" tab of the EMR revealed an order for a Ex Order 26. 4B1 [redacted] to be administered at bedtime for Ex Order 26. 4B1. This order was initiated on 07/27/23. Review of R89's July 2023 and August 2023 monthly "Medication Administration Records (MAR)" located in the "Orders" tab of the EMR revealed R89 received the Ex Order 26. 4B1 of Ex Order 26. 4B1 every night at bedtime from 07/27/23 to 08/01/23. Review of R89's Admission "MDS" assessment with an ARD of 08/01/23 specified, the resident had not received an Ex Order 26. 4B1 medication during the past seven days and had not received an Ex Order 26. 4B1 medication since admission to the facility. During an interview on 08/17/23 at 10:52 AM, the MDSC reviewed R89's EMR and confirmed the resident's 08/01/23 Admission "MDS" assessment was inaccurate because it did not reflect the resident received an Ex Order 26. 4B1 medication during the past seven days. NJAC 8:39-11.2(d)	F 641	then quarterly audits x2 on the completion and accuracy of MDS coding to reflect residents' medication status. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

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F 656	Continued From page 9	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		9/7/23

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F 656	Continued From page 10 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, the facility failed to develop a care plan for one of five residents (Resident (R) 89) reviewed for unnecessary medications regarding the resident's daily use of Ex.Order 26.4(b)(1) medication. Findings include: Review of R89's undated "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R89 was admitted to the facility on Ex Order 26. 4B1 with a diagnosis of Ex Order 26. 4B1. Review of R89's "Physician Orders" located in the "Orders" tab of the EMR revealed an order for a *Ex Order 26. 4B1* to be administered at bedtime for Ex Order 26. 4B1. This order was initiated on 07/27/23. Review of R89's July 2023 and August 2023 monthly "Medication Administration Records (MAR)" located in the "Orders" tab of the EMR revealed R89 received *Ex Order 26. 4B1* every night at bedtime from 07/27/23 to 08/16/23.	F 656	F 656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident R89's care plan was revised and care plan with reference to Ex Order 26. 4B1 was deleted. 2. 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 deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/designee will educate all nursing staff on initiating and editing care plans to be patient centered with	

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F 656	Continued From page 11 Review of R89's "Care Plan" located in the "Care Plan" tab of the EMR revealed a focus which indicated, "[R89's last name] uses Ex Order 26. 4B1 medication r/t [related to] Ex Order 26. 4B1 " initiated on 07/27/23. The care plan's only goal specified "The resident will show Ex Order 26. 4B1 through the review date." The care plan's interventions included, "Administer Ex Order 26. 4B1 medications as ordered by physician. Monitor for Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) (every)-SHIFT," and Ex.Order 26.4(b)(1) the resident for Ex.Order 26.4(b) The resident is taking Ex Order 26. 4B1 meds [medication] which are associated with an Ex Order 26. 4B1 ." R89's care plan did not include resident centered goals and interventions that addressed the resident's use of an Ex Order 26. 4B1 medication. During an interview on 08/17/23 at 10:52 AM, the Minimum Data Set Coordinator (MDSC) reviewed R89's EMR and confirmed R89 received Ex Order 26. 4B1 from 07/27/23 to 08/16/23 and the resident's care plan did not include goals and interventions that addressed the use of an Ex Order 26. 4B1 medication. Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered", dated 11/18, indicated, "Policy Resident population is long term and sub-acute therefore care plans need to be updated, for sub-acute on admission, after significant clinical change changes and as needed. For long term residents on admission, Quarterly or Annual or significant change and as needed . . . A comprehensive care plan for each	F 656	appropriate focus, goals, and interventions. 4. 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: DON/Designee will audit care plans for 5 residents with Ex.Order 26.4(b)(1) weekly x 4 weeks and monthly x 2. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. BUILDING _____ B. WING _____	C 08/18/2023

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F 656	Continued From page 12 resident is developed within seven days of completion of the resident assessment." NJAC 8:39-11.2(i)	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure staff provided the removal of facial hair for one of one dependent residents (Resident (R) 65) reviewed for *Ex Order 26. 4B1* in a total sample of 39 residents. Findings include: Observation on 08/14/23 at 10:06 AM, on 08/15/23 at 11:00 AM, and on 08/16/23 at 11:02 AM revealed the appearance of *Ex Order 26. 4B1* above R65's [redacted] and *Ex Order 26. 4B1* on [redacted]. Review of the Electronic Medical Record (EMR) "Diagnosis" tab revealed diagnoses for R65 that included *Ex Order 26. 4B1* [redacted]. Review of the annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/10/23, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15 indicating R65 was	F 677	F677 ADL Care Provided for Dependent Residents F677 CFR(s): 483.24(a)(2) 483.24(a)(2) A resident who is Ex.Order 26.4(b)(1) [redacted] receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident R65's Ex.Order 26. was immediately assessed and Ex.Order 26.4(b)(1) 2. 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 deficient practice. 3. WHAT MEASURES WILL BE PUT	9/7/23

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F 677	Continued From page 13 Ex Order 26. 4B1 . Further review of the "MDS" revealed R65 required Ex.Order 26.4(b)(1) person assistance for all Ex Order 26. 4B1 . Interview on 08/15/23 at 11:09 AM, Licensed Practical Nurse (LPN) 6 stated that she could not shave R65's Ex Order 26. 4B1 without a physician's order. Interview on 08/15/23 at 11:13 AM, LPN 2 stated that R65 was Ex Order 26. 4B1 and that she was not allowed to shave R65's Ex Order 26. 4B1 . Interview on 08/15/23 at 11:24 AM, LPN 8 stated that R65 did not like to be bothered and that the resident's son did not want staff to bother with shaving Ex Order 26. 4B1 . LPN 8 could not provide a care plan or documentation of son's instructions regarding R65's Ex Order 26. 4B1 . Review of the facility policy titled, 'Ex Order 26. 4B1 Supporting," dated 10/2022, indicated, "Appropriate care and services will be provided for residents who are unable to carry out Ex Order 26. 4 independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Ex.Order 26.4(b)(1) ..." NJAC 8:39-27.2(g)	F 677	INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Female residents known to have Ex.Order 26.4(b)(1) will be assessed 2 times per week on shower days and PRN and offered Ex.Order 26.4(b)(1 if needed. Facility wide in-services were conducted on resident rights and grooming. 4. 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: Audits will be conducted by ADON/or Designee with all female residents known to have Ex.Order 26.4(for grooming weekly x 1 month. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		9/7/23

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F 689	Continued From page 14 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to revise the care plan implement fall interventions to prevent future injuries from a [redacted] for one resident (Resident (R) 9) out of two residents reviewed for [redacted] from a total sample of 39 residents. The failure to update the care plan and implement revised Ex.Order 26.4(b)(1) for a resident with a history of [redacted] could result in serious injury. Findings include: Review of the facility's policy and procedure "[redacted] and [redacted], Managing," revised March 2018 and updated January 2023, indicated " . . . the staff, with the input of the attending physician, will implement a resident-centered Ex.Order 26.4(b)(1) plan to reduce the specific risk factor(s) of [redacted] for each resident at risk or with a history of [redacted]....staff will monitor and document each resident's response to interventions intended to reduce [redacted] or the risks of [redacted]...if interventions have been successful in preventing [redacted] staff will continue the interventions ..." Review of R9's undated "Admission Record," located in the resident's Electronic Medical Record (EMR) under the "Profile" tab indicated an admission date to the facility of [redacted] and diagnoses of *Ex Order 26. 4B1* [redacted]	F 689	F689 Accidents. The facility must ensure that - 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and 483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident R9's [redacted] interventions in the care plan were updated and [redacted] discontinued. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTIC: All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Nursing assistants, Nurses, and Unit Manager were educated regarding the need of [redacted] the	

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F 689	Continued From page 15 Review of R9's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 03/28/23 and located in the EMR under the "MDS" tab, revealed R9's Brief Interview for Mental Status score was [redacted] which indicated R9 was *Ex Order 26. 4B1* and could [redacted] the assessment, required Ex.Order 26.4(b)(1) [redacted] Review of R9's [redacted] Incident Report" dated 06/13/23 revealed R9 had an unwitnessed [redacted] on 06/13/23 at 12:15 AM where R9 " ...was observed on the floor *Ex Order 26. 4B1* from swelling that is open on *Ex Order 26. 4B1* ..." R9 was unable to state what happened. R9 was sent out to the Ex.Order 26.4(b)(1) [redacted] to the facility on *Ex Order 26. 4B1*. [redacted] report from 06/13/23 revealed " ... [redacted] as well as *Ex Order 26. 4B1* to the *Ex Order 26. 4B1* and [redacted] ..." The history and physical (H&P) completed at the [redacted] revealed " Ex.Order 26.4(b)(1) and *Ex Order 26. 4B1* from what appears to be *Ex Order 26. 4B1* [redacted] on the *Ex Order 26. 4B1* and *Ex Order 26. 4B1* [redacted] ..." Follow up notes revealed " ...resident with Ex.Order 26.4(b)(1) . Team agreed that resident will be in dayroom when awake ..." No other interventions were noted in the follow-up report. Review of the "Care Plan" tab in the EMR revealed R9's comprehensive "care plan", dated 11/15/21, and revised on 06/13/23 revealed " ...continue interventions on the at-risk plan ..." The "care plan" revealed new interventions for R9	F 689	resident's Ex.Order 26.4(b)(1) after care. Unit Manager was educated on the importance of updating the care plan to reflect the current interventions discussed with IDC team. 4. 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 DON/Designee will audit 5 residents with Ex.Order 26.4(b)(1) weekly x 4, monthly x 2. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

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F 689	Continued From page 16 were implemented on 06/13/23, after R9 was sent to the [redacted], which included " ...use of [redacted] and continue use of [redacted] ..." The intervention discussed by the team in follow up to the 06/13/23 [redacted] for R9 to be in the dayroom when awake was not included on the [redacted] care plan. During an observation on 08/14/23 at 4:00 PM, R9 was observed lying in bed, in [redacted] room. R9 was positioned on [redacted], with the head of the bed (HOB) up and the knees bent to prevent R9 from sliding down in the bed. The bed [redacted]. No [redacted] were observed by the bed or in the room. The call light was observed attached to the bed but was not accessible to R9. During an observation on 08/15/23 at 9:15 AM, R9 was observed in [redacted] room, lying in bed. No [redacted] were noted by the bed or in the room. The call light was observed attached to the bed but was not accessible to R9. During an observation on 08/15/23 at 11:00 AM, R9 was observed in her room, lying in bed. No [redacted] were noted by the bed or in the room. The bed was [redacted]. The call light was observed attached to the bed but was not accessible to R9. During an observation on 08/15/23 at 4:30 PM, R9 was observed in [redacted] room, lying in bed positioned on [redacted]. No [redacted] were noted by the bed or in the room. Bed was not observed to [redacted] bed. The call light was observed attached to the bed but was not accessible to R9.	F 689		

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F 689	Continued From page 17 During an observation on 08/16/23 at 8:30 AM, R9 was observed in [redacted] room, lying in bed positioned on [redacted] back. No [redacted] were noted by the bed or in the room. Bed was observed to be in the Ex.Order 26.4(b)(1). After R9 was fed [redacted] breakfast, the bed was noted to be left at approximately waist height. The call light was observed attached to the bed but was not accessible to R9. Review of R9's "Care Plan" tab in the EMR revealed no documentation on the "care plan" of an intervention that R9 was to Ex.Order 26.4(b)(1) to prevent [redacted] from the *Ex Order 26. 4B1*. During an interview on 08/16/23 at 11:25 AM the unit manager (UM) stated she thought R9 had [redacted] by [redacted] bed and during an observation of R9's room with the UM, no [redacted] were observed by the bed or in the room. The UM stated " ...I guess she (R9) doesn't have them. Not sure if there is an order for them ..." The UM was unaware of the care plan intervention that included [redacted] by the bed. The UM also stated during the observation that R9's bed was not in the Ex.Order 26.4(b)(1). During an interview on 08/17/23 at 12:40 PM the DON stated the [redacted] and the [redacted] intervention implemented on 06/13/23 were " ...No longer necessary as R9 has had a change in *Ex Order 26. 4B1* since the [redacted] in June and going on [redacted] ..." The DON also stated during the interview the [redacted] were an " ...immediate intervention following the [redacted] ..." and was unable to confirm whether the [redacted] were implemented on R9's return on [redacted] The	F 689		

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F 689	Continued From page 18 DON was unaware the [redacted] and [redacted] interventions remained on the care plan as of 08/16/23.	F 689		
F 695 SS=D	NJAC 8:39-27.1(a) 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, record review, and facility policy review, the facility failed to maintain the cleanliness of the [redacted] when not in use for one of 39 residents in the survey sampled (Resident (R) 30. This deficient practice increases the risk of infection for a resident requiring [redacted]. Findings include: Review of R30's Electronic Medical Record (EMR) undated "Face Sheet" located under the "Profile" tab, indicated R30 was admitted to the facility on [redacted] with diagnosis of [redacted]. Review of R30's quarterly "Minimum Data Set (MDS)" located in R30's EMR under the "MDS"	F 695	F695 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. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident R30 was assessed by primary nurse. [redacted] was removed. Order was discontinued on	9/7/23

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F 695	Continued From page 19 tab, with an Assessment Reference Date (ARD) of 06/07/23, revealed a score of [redacted] of 15 which indicated R30 was *Ex Order 26. 4B1*. Review of R30's "Physician Orders" located in R30's EMR under the "Orders" tab, revealed orders dated 08/04/202 *Ex Order 26. 4B1* [redacted] by mouth per *Ex Order 26. 4B1* treatment every four hours. During an observation and interview with Unit Manager (UM) on 08/14/23 at 12:15 PM, R30's *Ex Order 26. 4B1* was lying directly on the bedside table. The UM was asked how a *Ex Order 26. 4B1* was to be stored when not in use and she stated, *Ex Order 26. 4B1* During an observation conducted on 08/16/23 at 2 PM, R30's *Ex Order 26. 4B1* was lying directly on the bedside table. Licensed Practical Nurse (LPN) 7 went into the resident's room and was asked how the *Ex Order 26. 4B1* was to be stored when not in use. LPN7 replied, *Ex Order 26. 4B1* [redacted] During an interview on 08/17/23 at 10:30AM, the regional clinical nurse and Director of Nursing (DON) was notified of R30's *Ex Order 26. 4B1* [redacted] lying directly on the bedside table when not in use. The DON stated, *Ex Order 26. 4B1* [redacted] Review of the facility's policy titled, "Departmental-Respiratory Therapy-Prevention of Infection" with reviewed date of 03/2021 stated, " ...Store the circuit in plastic bag ...between uses ..." NJAC 8:39-19.4(k)	F 695	8/12/2023. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE DEFICIENT PRACTICE: All residents have the potential to be affected by the deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/Designee educated all nurses regarding active physician orders and proper storage of respiratory equipment when not in use. 4. 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: DON/Designee will audit physician orders for 5 residents with Ex.Order 26.4(b)(1) orders weekly x 4 weeks and monthly x 2. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

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F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure prescribed medications were available for administration for one of eight residents (Resident (R) 49) whose drug regimen was reviewed. The facility failed to have R49's Ex Order 26.4(b)(1) medication available to administer as prescribed which caused the resident to not to feel well on the days it was not administered. Findings include: . Review of R49's undated "Admission Record" located in the "Profile" tab of the electronic medical record (EMR), revealed R49 was admitted to the facility on Ex Order 26. 4B1 with a diagnosis of *Ex Order 26. 4B1* . Review of R49's Annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/15/23, located in the EMR under the "MDS" tab, indicated R49 had a Brief Interview for Mental Status (BIMS) score of Ex Ord of 15, which indicated the resident was *Ex Order 26. 4B1* . The MDS also indicated R49 had a diagnosis of Ex Order 26. 4B1 . Review of R49's current "Physician Orders" located in the "Orders" tab of the EMR revealed an order for *Ex Order 26. 4B1* Give one tablet by mouth two times a day for Ex Order 26. 4B1 ." This order was initiated on	F 760	Deficiency: F760 The facility must ensure that its483.45(f)(2) Residents are free of any significant medication errors 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident R49's orders were reviewed, and medication was readily available to administer. Nurses were educated on reordering medications from pharmacy. 2. 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 deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/designee will educate all nurses on the process of following up on medication availability to administer medications. DON/designee will ensure nurses report to the Unit Manager or	9/7/23

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F 760	Continued From page 21 02/09/23. Review of R49's EMR July 2023 monthly "Medication Administration Record (MAR)" located under the "Orders" tab revealed R49 was to receive a Ex Order 26. 4B1 twice a day at 9:00 AM and 5:00 PM. Further review of R49's July 2023 "MAR" revealed staff documented the resident did not receive the Ex Order [redacted] on 07/13/23 at 5:00 PM, on 07/14/23 at 9:00 AM and 5:00 PM, on 07/15/23 at 9:00 AM and 5:00 PM, on 07/30/23 at 5:00 PM, and on 07/31/23 at 9:00 AM. Review of R49's "Progress Notes" located in the "Prog [Progress] Note" tab of the EMR revealed the following entries: 07/13/23 at 4:53 PM: "Ex Order 26. 4B1 Give Ex.Order 26.4(b)(1) a day for Ex Order 2[redacted] awaiting delivery." 07/14/23 at 2:49 PM: "Ex Order 26. 4B1 by mouth Ex.Order [redacted] medication on order." 07/14/23 at 6:37 PM: "Ex Order 26. 4B1 give 1 tablet by Ex.Order 26.4(b)(1) a day for Ex Order 26. 4B1 unable to reorder." 07/15/23 at 9:48 AM: "Ex Order 26. 4B1 Give 1 tablet by mouth Ex.Order 26.4(b)(1) for Ex Order 2[redacted] awaiting for delivery from pharmacy." 07/15/23 at 3:13 PM: "Called pharmacy and the rep. [representative] stated the Ex Order 26. 4B1 will be delivered today." 07/15/23 at 4:38 PM: "Ex Order 26. 4B1	F 760	Supervisor when a medication is delayed from pharmacy for immediate follow up and physician to be notified. 4. 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: DON/Designees will conduct 2 medication pass evaluation weekly x 4 weeks then 2 medication pass evaluations bimonthly x 2 months. DON/designee will conduct a weekly audit of MAR and TAR for missing medication administration. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

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F 760	Continued From page 22 Give 1 tablet Ex.Order 26.4(b)(1) a day for Ex Order 26. 4B1 Awaiting delivery, reordered." 07/30/23 at 5:16 PM: Ex Order 26. 4B1 Give 1 tablet by mouth Ex.Order 26.4(b)(1) a day for Ex Order 2 med [medication] not available. Phar [Pharmacy] aware." 07/31/23 at 2:33 PM: 'Ex Order 26. 4B1 Give 1 tablet by mouth Ex.Order 26.4(b)(1) a day for Ex Order 2 Medication to be delivered." During an interview on 08/15/23 at 8:30 AM, R49 stated Ex Order 26. 4B1 The resident specified Ex Order felt this way because Ex Order was to receive Ex Order Ex Order 26. 4B1 twice a day, but during the past month the facility ran out of this medication on two occasions which resulted in Ex Order missing multiple doses. R49 specified during the first occurrence Ex Order did not receive the Ex Order 2 medication for three days. R49 further explained the second occurrence was at the end of July and Ex Order did not receive the Ex Order 2 medication on a Saturday evening and on the following Sunday morning. R49 stated the nurses informed Ex Order that Ex Order Ex Order 26. 4B1 were not available because there was a delay in obtaining them from the pharmacy. R49 stated the nursing staff should have seen when Ex Order Ex Order 26. 4B1 were running out and reordered them before they ran out. During an interview on 08/17/23 at 9:30 AM, R49 stated when Ex Order did not receive Ex Order Ex Order 26. 4B1 Ex Order stomach did not feel good and Ex Order could not think as clearly. R49 stated it was "frustrating" for staff not to look ahead and reorder Ex Order Ex Order 26. 4B1 in time to always have this medication available. During an interview on 08/17/23 at 8:30 AM,	F 760		

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F 760	Continued From page 23 Clinical Regional Supervisor (CRS)1 confirmed staff did not administer R49's [Ex Order 26. 4B1] medication on 07/13/23 at 5:00 PM, on 07/14/23 at 9:00 AM and 5:00 PM, and on 07/15/23 at 9:00 AM and 5:00 PM because the medication was not available in the facility to administer. CRS1 stated R49's [Ex Order 26. 4B1] medication was obtained on 07/16/23. During an interview on 08/17/23 at 3:50 PM, the Consulting Pharmacist stated he did not work at the pharmacy who dispensed the medication, but [Ex Order 26. 4B1] should be readily available because he was unaware of any shortages of this medication. During an interview on 08/17/23 at 4:40 PM CRS1 confirmed staff did not administer R49's [Ex Order 26. 4B1] medication on 07/30/23 at 5:00 PM and on 07/31/23 at 9:00 AM because the medication was not available in the facility to administer. CRS1 stated the facility did not have a policy that addressed when a resident's medication was not available. CRS1 stated if a resident's medication was not available, he would expect the resident's nurse to contact the resident's physician, the pharmacy, the resident, and/or the resident's responsible party. Review of the facility's policy titled, "Administering Medications," dated 10/22, indicated, "Medications shall be administered in a safe and timely manner, and as prescribed." NJAC 8:39-29.2(d)	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink	F 804		9/7/23

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F 804	Continued From page 24 Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Resident Council minutes, and facility policy review, the facility failed to serve food that was palatable to three of five residents (Resident (R) 49, R53, and R61) reviewed for food palatability. This failure had the potential to affect all 164 residents who consumed food prepared from the facility's kitchen. Findings include: 1. Review of Resident Council meeting minutes dated 06/22/23, provided by the facility, revealed, "For certain meals, the bread can get soggy when it is served with certain side dishes." Review of the Resident Council meeting minutes dated 03/23/23 revealed, "Residents feel the drinks and juices are sometimes not cold enough or partially frozen. At times, the food served on the units is not hot enough. The hot tea and coffee aren't always hot enough by the time the residents get it on the units." Review of the Resident Council meeting minutes dated 05/25/23 revealed, "The French fries are not served warm." 2. Review of R49's Annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/15/23, located in the Electronic Medical Record (EMR) under the "MDS" tab,	F 804	POC F804 palatability All residents had the potential to be affected by this deficient practice. The Food Service Director met with each of the 3 residents to review their concerns and address accordingly. All kitchen staff who cook were in-serviced regarding always utilizing the documented recipes and seasonings for the items that are indicated on the menu, including the mashed potatoes recipe. Recipes are posted on a weekly basis and are readily available every day. In addition, staff were in- serviced regarding separating the bread/toast from the breakfast eggs so that they wouldn't be soggy, assuring that the cold drinks are cold and not frozen, and that the hot food is within acceptable parameters. All kitchen staff were in serviced on menu substitutions, and the requirement to log and track any menu item substitutions. Items requested to be changed for a resident must be discussed and cleared by the Food Service Director or the Kitchen Supervisor	

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F 804	Continued From page 25 indicated R49 had a Brief Interview for Mental Status (BIMS) score of [redacted] of 15, which indicated the resident was *Ex Order 26. 4B1*. Observation on 08/15/23 at 8:15 AM revealed R49 was eating [redacted] breakfast meal in [redacted] room. Observations of R49's breakfast tray revealed a wet napkin was in the middle of [redacted] plate with scrambled eggs beside the wet napkin. R49's toast was set off to the side of [redacted] plate and the toast was wet. During an interview on 08/15/23 at 8:15 AM, R49 stated the scrambled eggs served with [redacted] breakfast meal were watery and greasy, so [redacted] used a napkin to remove the liquid from around the eggs that were on [redacted] plate. The resident stated [redacted] toast was wet because it was served on the same plate as the scrambled eggs. The resident stated [redacted] breakfast meal was "not appetizing." R49 also stated food served at meals was not always seasoned and lacked flavor. R49 specified the mashed potatoes served at meals were prepared from dried potatoes and were tasteless because they were not seasoned. 3. A group interview was conducted on 08/16/23 at 3:45 PM with five residents whom the facility identified as reliable historians. During the meeting, three of the five residents (R49, R53, and R61) voiced concerns about the food served at the facility. The three residents stated the food served at meals lacked seasoning and did not always taste good. Review of R53" Quarterly "MDS" with an ARD of 06/27/23 revealed a BIMS score of [redacted], which indicated the resident had *Ex Order 26. 4B1* [redacted].	F 804	The Food Service Director or designee will conduct a random biweekly audit for 2 months of several menu items to ascertain that the printed recipe was followed accurately, to check on food quality and presentation as well as appropriate temperature of all items leaving the kitchen. Results of these audits will be shared with the QA committee on a monthly basis.	

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F 804	Continued From page 26 Review of R61's Quarterly "MDS" with an ARD of 07/12/23 revealed a BIMS score of [redacted], which indicated that resident *Ex Order 26. 4B1* [redacted]. 4. In response to resident complaints about food, a test tray was requested to be sent to the facility's second floor during the lunch meal on 08/16/23. Observation revealed before the tray cart left the kitchen temperature monitoring of food being served from the kitchen's tray line was at acceptable levels, of greater than 140 degrees Fahrenheit (F). Observation revealed resident meal trays were placed on an enclosed tray cart without heating element, with the test tray, and the cart left the kitchen at 12:52 PM. The tray cart was delivered to the second floor at 12:55 PM. The last resident meal was served from the tray cart on 08/16/23 at 1:09 PM. At this time, internal temperatures of the food on the test tray were monitored and the food was tasted with the facility's Director of Food Service (DFS). Tasting of the food served on the test tray revealed: The meat loaf, mashed potatoes and carrots served on the test tray were hot when tasted. However, the mashed potatoes tasted bland and lacked seasoning. The DFS also tasted the mashed potatoes and agreed they lacked seasoning. During an interview on 08/16/23 at 1:30 PM Cook 5 stated she prepared the mashed potatoes served at the lunch meal of 08/16/23. Cook 5 explained when she prepared the mashed potatoes, she used dried potato mix from a can, water, a little garlic, and some melted margarine. Cook 5 stated she did not measure any of these	F 804		

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F 804	Continued From page 27 ingredients when she prepared the mashed potatoes. Cook 5 stated a facility recipe was available for the mashed potatoes, but she did not utilize the recipe. Review of the facility's recipe for the mashed potatoes revealed the ingredients in the recipe included measured amounts of dry mashed potato mix, hot water, salt, ground nutmeg, ground black pepper, sour cream, pasteurized whole liquid egg with citric acid and cream cheese. During an interview on 08/16/23 at 1:35 PM the DFS agreed Cook 5 did not follow the recipe when she prepared the mashed potatoes for the 08/16/23 lunch meal. The DFS stated staff were expected to follow recipes when they prepared food for resident meals. Review of the facility's undated policy titled, "Food Quality and Palatability," indicated, "Policy Statement Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. . .. Procedures 1. The Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to menu, production guidelines and standardized recipes. . . 4. The Cook(s) prepare food in accordance with the recipes, season for region and/or ethnic preferences, as appropriate. Cook(s) use proper cooking techniques to ensure color and flavor retention." NJAC 8:39-17.4(a)2	F 804		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3)	F 809		9/7/23

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F 809	Continued From page 28 §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's meal schedule, and facility policy review, the time span between the residents' evening meal and the following breakfast meal exceeded 14 hours and the time span between these two meals was not approved by five of five residents (Resident (R) 47, R49, R53, R61, and R118) who regularly attended the monthly resident council meetings and were interviewed regarding the facility's meal schedule. This failure had the potential to affect 164 residents who received meals from the facility's kitchen. Findings include: 1. Review of the facility's undated meal schedule that was on the "Mealtime Delivery Log" revealed,	F 809	F 809 mealtimes/ snacks All residents had the potential to be affected by this deficient practice. The time between the substantive evening dinner and breakfast is often over 14 hours, and we therefore will continue to provide nourishing snacks after dinner, as has been our past practice. Snacks are delivered to each unit and offered/distributed by the nursing staff after the dinner meal. Staff were reeducated regarding this protocol. At the monthly Resident Council meeting	

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F 809	Continued From page 29 the following "Projected Arrival Time" when each hallway was scheduled to receive their dinner and breakfast meals: First floor East North Hallway: Dinner 5:10 PM and Breakfast 7:25 AM. A total of 14 hours and 15 minutes were scheduled between the resident evening meal and the following breakfast meal. First floor East South Hallway: Dinner 5:25 PM and Breakfast 7:40 AM. A total of 14 hours and 15 minutes were scheduled between the resident evening meal and the following breakfast meal. Second floor West North Hallway: Dinner 5:30 PM and Breakfast 7:55 AM. A total of 14 hours and 25 minutes were scheduled between the resident evening meal and the following breakfast meal. Second floor West South Hallway: Dinner 5:35 PM and Breakfast 8:10 AM. A total of 14 hours and 35 minutes were scheduled between the resident evening meal and the following breakfast meal. Second floor East North Hallway: Dinner 5:45 PM and Breakfast 8:25 AM. A total of 14 hours and 40 minutes were scheduled between the resident evening meal and the following breakfast meal. Second floor East South Hallway: Dinner 5:55 PM and Breakfast 8:40 AM. A total of 14 hours 45 minutes were scheduled between the resident evening meal and the following breakfast meal. First floor West North Hallway: Dinner 6:05 PM and Breakfast 8:55 AM. A total of 14 hours 50 minutes were scheduled between the resident	F 809	held on August 24, 2023, the Administrator clearly reviewed the 14 hour between-meal regulation, and asked if the residents are satisfied with a nourishing snack of their choosing after dinner, as has been the ongoing practice. No objections were raised, and the group agreed to maintain the current mealtimes with snacks provided. In addition, after the Resident Council meeting, the President of the Resident Council signed a “Complete Care Snack Program Agreement” on August 30, 2023, which delineates the above stipulations and protocol, and verifies that the matter was discussed with the resident council members. The Director of Nursing / Evening Supervisor/ designee will audit 5 residents at random for 3 days per week for 2 months, to assure that a nourishing snack is offered. Results of these audits will be presented to the Administrator at the QAPI meeting, which is held quarterly, for discussion and follow up if needed.	

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F 809	Continued From page 30 evening meal and the following breakfast meal. First floor West South Hallway: Dinner 6:15 PM and Breakfast 9:10 AM. A total of 14 hours and 55 minutes were scheduled between the resident evening meal and the following breakfast meal. 2. Review of R49's Annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 05/15/23, located in the Electronic Medical Record (EMR) under the "MDS" tab, indicated R49 had a Brief Interview for Mental Status (BIMS) score of [redacted] of 15, which indicated the resident was *Ex Order 26. 4B1*. During an interview on 08/15/23 at 8:15 AM, R49 stated [redacted] was a longtime resident at the facility, and regularly attended the monthly resident council meetings. R49 stated [redacted] did not recall staff ever asking residents for their approval on having a time span that exceeded 14 hours between their evening meal and their following breakfast meal. R49 also stated [redacted] was not always offered a bedtime snack. The resident explained some staff offered [redacted] a snack at bedtime and other staff did not. 3. A group interview meeting was conducted on 08/16/23 at 3:45 PM with five residents whom the facility identified as reliable historians, and who regularly attended the monthly resident council meetings. During the meeting, five of the five residents (R47, R49, R53, R61, and R118) indicated they did not recall being asked by staff for their approval regarding the time span between their evening meal and their following breakfast meal exceeding 14 hours. Review of R53's Quarterly "MDS" with an of ARD	F 809		

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F 809	Continued From page 31	F 809		

of 06/27/23 revealed a BIMS score of [redacted] out of 15, which indicated the resident's cognition was *Ex Order 26. 4B1* [redacted].

Review of R61's Quarterly "MDS" with an ARD of 07/12/23 revealed a BIMS score of [redacted] out of 15, which indicated the resident was *Ex Order 26. 4B1* [redacted].

Review of R47's Annual "MDS" with an ARD of 07/20/23 revealed a BIMS score of [redacted] out of 15, which indicated the resident was *Ex Order 26. 4B1* [redacted].

Review of R118's Quarterly "MDS" with an ARD of 0705/23 revealed a BIMS score of [redacted] out of 15, which indicated the resident was *Ex Order 26. 4B1* [redacted].

4. Review of the facility's "Mealtime Delivery Logs" for 08/15/23 and 08/16/23 revealed staff documented the following times on 08/15/23 when the dinner meal arrived on each hallway and the following times on 08/16/23 when the breakfast meal arrived on each hallway:

First floor East North Hallway: The 08/15/23 dinner meal arrived on hallway at 4:35 PM and the 08/16/23 breakfast meal arrived on hallway at 7:34 AM. A total of 14 hours and 59 minutes elapsed between the resident evening meal and the following breakfast meal arriving on this hallway.

First floor East South Hallway: The 08/15/23 dinner meal arrived on the hallway at 4:46 PM and the 08/16/23 breakfast meal arrived on the hallway at 7:40 AM. A total of 14 hours and 54 minutes elapsed between the resident evening

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F 809	Continued From page 32	F 809		

meal and the following breakfast meal arriving on the hallway.

Second floor West North Hallway: The 08/15/23 dinner meal arrived on the hallway at 4:59 PM and the 08/16/23 breakfast meal arrived on the hallway at 7:50 AM. A total of 14 hours and 51 minutes elapsed between the resident evening meal and the following breakfast meal arriving on this hallway.

Second floor West South Hallway: The 08/15/23 dinner meal arrived on the hallway at 5:21 PM and the 08/16/23 breakfast meal arrived on the hallway at 7:55 AM. A total of 14 hours and 34 minutes elapsed between the resident evening meal and the following breakfast meal arriving on this hallway.

Second floor East North Hallway: The 08/15/23 dinner meal arrived on the hallway at 5:36 PM and the 08/16/23 breakfast meal arrived on the hallway at 8:15 AM. A total of 14 hours and 39 minutes elapsed between the resident evening meal and the following breakfast meal arriving on this hallway.

Second floor East South Hallway: The 08/15/23 dinner meal arrived on the hallway at 5:54 PM and the 08/16/23 breakfast arrived on the hallway at 8:20 AM. A total of 14 hours 26 minutes elapsed between the resident evening meal and following breakfast meal arriving on this hallway.

First floor West North Hallway: The 08/15/23 dinner meal arrived on the hallway at 6:09 PM and the 08/16/23 breakfast meal arrived on the hallway at 8:35 AM. A total of 14 hours and 26 minutes elapsed between the resident evening

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COMPLETE CARE AT CEDAR GROVE	**536 RIDGE ROAD CEDAR GROVE, NJ 07009**

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F 809	Continued From page 33 meal and the following breakfast meal arriving on this hallway. First floor West South Hallway: The 08/15/23 dinner meal arrived on the hallway at 6:10 PM and the 08/16/23 breakfast meal arrived on the hallway at 8:45 AM. A total of 14 hours and 35 minutes elapsed between the resident evening meal and the following breakfast meal arriving on this hallway. 5. Observation of the evening meal on 08/15/23 revealed the meals were delivered to the second floor East North Hallway at 5:36 PM. Observations of the 08/16/23 breakfast meal revealed the meals were delivered to the second floor East North Hallway at 8:15 AM. A total of 14 hours and 39 minutes elapsed between the 08/15/23 resident evening meal being delivered to the second floor East North Hallway and the 08/16/23 resident breakfast meal being delivered to this hallway. 6. Observation of the evening meal on 08/15/23 revealed the meals were delivered to the second floor East South Hallway at 5:54 PM. Observations of the 08/16/23 breakfast meal revealed the meals were delivered to the second floor East South Hallway at 8:20 AM. A total of 14 hours and 26 minutes elapsed between the 08/15/23 resident evening meal being delivered to the second floor East South Hallway and the 08/16/23 resident breakfast meal being delivered to this hallway. During an interview on 08/17/23 at 9:40 AM the Director of Food Services (DFS) confirmed the meal arrival times documented on the "Mealtime Delivery Logs" for the 08/15/23 evening meal and	F 809		

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F 809	Continued From page 34 the 08/16/23 breakfast meal were greater than 14 hours between these two meals for each facility hallway. The DFS stated the kitchen provided each hallway with a tray of bedtime snacks for the residents and the nursing staff were to offer these snacks to the residents each night. During an interview on 08/17/23 at 1:15 PM the Administrator stated he had been the facility's Administrator for about a year. The Administrator stated to his knowledge the residents had not been asked by the facility for their approval of the meal span between the evening meal and following breakfast meal exceeding 14 hours. The Administrator stated he had not received any resident complaints regarding the facility's meal schedule or about staff failing to offer residents bedtime snacks. Review of the facility's undated policy titled, "Frequency of Meals," indicated, "Policy Statement At least three daily meals will be provided, at regular times comparable to normal mealtimes in the community. The time between a substantial evening meal and breakfast the following day will not exceed 14 hours, except when a nourishing snack is served at bedtime. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to the meal span and a nourishing snack is provided. Suitable, nourishing alternative meals and snacks will be provided to a resident who wants to eat at non-traditional times outside of scheduled mealtimes and consistent with the resident plan of care." NJAC 8:39-17.2(f)	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		9/7/23

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F 812	Continued From page 35 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure coffee pitchers and the juice machine's dispenser nozzle were dry when stored, kitchen ceiling tiles were free of mold, kitchen storage racks were clean and kitchen sanitizing buckets contained adequate quaternary ammonia to sanitize kitchen equipment and food preparation surfaces. This failure had the potential to affect 164 residents who consumed food prepared from the facility's kitchen. Findings included: 1. Observation during the initial kitchen inspection on 08/14/23 from 9:00 AM to 9:40 AM, with	F 812	F812 Food Procurement, Store/Prepare/Serve – Sanitary All residents had the potential to be affected by these deficient practices. The issues cited during the survey were immediately addressed as follows: 1) Ceiling tiles were cleaned 8/14/23. Maintenance replaced the old tiles with brand new tiles on 8/16/23. 2) All affected coffee pitchers were cleaned, sanitized, and set to air dry appropriately. All kitchen staff in serviced on proper air-drying protocol. 3) All kitchen staff were in serviced on	

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F 812	Continued From page 36 Director of Food Services (DFS) present, revealed the following: a. Four coffee pitchers with their lids tightly closed were stored wet with accumulated water in each pitcher. b. Eight kitchen ceiling tiles, located above the kitchen's large coffee maker, had black mold growth on them. c. The juice machine's dispensing nozzle was stored in a small container of unclean water. The dispensing nozzle was in direct contact with the unclean water. d. Observation of the DFS using test paper to check the amount of quaternary ammonia sanitizer in three kitchen sanitizing buckets, which were utilized to sanitize kitchen equipment and food preparation surfaces, revealed one bucket contained only 25 parts per million (ppm) of quaternary ammonia, and the other two buckets contained zero ppm of quaternary ammonia. e. The kitchen's two large metal can storage racks, with cans of food stored on them, had accumulated loose food debris and dried sticky substances on their metal tracks where cans were stored. During an interview on 08/14/23 at 9:40 AM, the DFS stated coffee pitchers and the juice machine's dispensing nozzle should be dry when stored, kitchen ceiling tiles should be free of mold, and food storage racks should be kept clean. The DFS confirmed the three sanitizing buckets tested for quaternary ammonia did not contain enough sanitizer to sanitize food	F 812	how to properly clean the juice gun nozzle 4) All kitchen staff in serviced on proper use of sanitizer buckets and how to measure the correct PPM, with return demonstrations. 5) Can rack was power washed immediately. Storage room shelves and racks were added to the cleaning schedule. All kitchen staff were in serviced. The director of Food Service will conduct a thorough weekly review of all equipment and kitchen areas to ensure that all aspects of the kitchen functioning will be maintained in a clean and sanitary manner. In-services will be conducted as needed if any areas need reeducation, including acceptable sanitizer amounts. This audit will continue weekly for 3 months, and results will be shared with the Administrator at the QAPI meeting which is held quarterly, with corrective actions implemented if needed.	

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F 812	Continued From page 37	F 812		

preparation surfaces and equipment. The DFS stated the kitchen sanitizing buckets should contain between 150 ppm to 400 ppm of quaternary ammonia per the manufacturer's instructions that were observed posted in the kitchen's three compartment sink area.

2. Observation on 08/16/23 at 1:40 PM, the DFS used test paper to check the amount of quaternary ammonia sanitizer in two kitchen sanitizing buckets, revealed one bucket contained only 15 ppm of quaternary ammonia, and the other bucket measured zero ppm quaternary ammonia.

During an interview on 08/16/23 at 1:45 PM, the DFS confirmed the two sanitizing buckets tested did not contain sufficient quaternary ammonia to sanitize food preparation surfaces and equipment. The DFS stated the sanitizing buckets should contain between 150 ppm to 400 ppm of quaternary ammonia per the manufacturer's instructions that were observed posted in the kitchen's three compartment sink area. The DFS stated staff should check the amount of quaternary ammonia in each sanitizing bucket prior to placing the bucket in the kitchen for use to make sure it contains between 150 ppm to 400 ppm to effectively sanitize equipment and food preparation surfaces.

Review of the facility's undated policy titled, "Environment," revealed, "Policy Statement All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. Procedures 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and

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F 812	Continued From page 38 ventilation. 2. The Dining Service Director will ensure that all employees are knowledgeable of the proper procedures for cleaning and sanitizing of all food service equipment and surfaces. 3. All food contact surfaces will be cleaned and sanitized after each use. 4. The Dining Service Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces." NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		
F 868 SS=F	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect	F 868		9/7/23

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F 868	Continued From page 39 to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, the Quality Assurance and Performance Improvement (QAPI) committee failed to hold quarterly meetings for one of four QAPI meetings conducted. This failure had the potential to affect all 170 residents who currently live in the facility. Findings include: Review of the facility" QAPI sign-in log" dated 12/14/22 was for the third quarter of 2022 that included July 2022, August 2022, and September 2022. Review of the facility's "QAPI sign-in log" dated 01/25/23 was for the fourth quarter of 2022 that included October 2022, November 2022, and December 2022. Review of the facility's "QAPI sign-in log" dated 04/26/23 was for the first quarter of 2023 that included January 2023, February 2023, and March 2023.	F 868	F 868 QAPI meetings All residents had the potential to be affected by this deficient practice. All future QAPI quarterly meetings shall be held on the month directly following the end of each quarter, as per our policy, delineated below: January for the prior year's 4th quarter, April for the first quarter, July for the second quarter, and October for the third quarter. All Qapi team members were educated regarding this requirement. The administrator will conduct a QA audit for the next 3 meetings to assure that they occur in the proper month and will present those findings to the QAPI committee which meets quarterly.	

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F 868	Continued From page 40 Review of the facility's "QAPI sign-in log" dated 07/26/23 was for the second quarter of 2023 that included April 2023, May 2023, and June 2023. Review of the facility's undated document titled, "Complete Care at Cedar Grove QAPI Plan," revealed, " ...2. Governance and Leadership: The QAPI Plan will be Organized and Orchestrated by Administrator, DON (Director of Nursing) and Medical Director and a system that sets expectations and review of safety, quality, rights, choice and respect for resident rights and choice." The document failed to address the requirement of holding quarterly meetings. During the QAPI interview on 08/17/23 at 5:15 PM, the Administrator stated that "the QAPI committee meets quarterly and is attended by the Medical Director, DON, Administrator and department heads." When the sign-in logs were reviewed the Administrator stated, "We realized that we missed our quarterly meeting for the third quarter of 2022, that should have been held in October 2023. We then held the third quarter QAPI meeting in December 2022 and returned to the regular meeting schedule after that." NJAC 8:39-33.1(a)	F 868		

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S 000	Initial Comments The facility is 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 review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	S 560 staffing ratios All residents have the potential to be affected by this deficient practice. Mandated staffing ratios as required by DOHNJ were communicated to the Staffing Coordinator and Nursing Supervisors to always match CNA ratios of 1:8 on day shift, 1:10 on evening shift, and 1:14 on the night shift. Center staffing schedule ratios are developed, reviewed and posted 2 weeks prior to utilization, to comply with required ratios. DON and Staffing Coordinator were reeducated regarding acceptable staffing	9/7/23

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

Electronically Signed | 09/05/23

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on day shifts as follows: For the 2 weeks of Complaint staffing from 06/13/2021 to 06/26/2021, the facility was deficient in CNA staffing for resident on 14 of 14 day shifts and deficient in total staff to CNAs on 1 of 14 evening shifts as follows: -06/13/21 had 9 CNAs for 123 residents on the day shift, required at least 15 CNAs. -06/14/21 had 8 CNAs for 123 residents on the day shift, required at least 15 CNAs. -06/15/21 had 9 CNAs for 122 residents on the day shift, required at least 15 CNAs. -06/16/21 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/17/21 had 10 CNAs for 121 residents on the	S 560	ratios, and will meet weekly to review the 4-week master schedule to ensure that it has been scheduled according to the mandated ratios. If staffing deficits are identified, the facility will immediately communicate the availability of unfilled shifts to in-house staff as well as multiple contracted agency personnel, for coverage. The Center will continue external recruitment efforts to fill open positions and will continue to offer bonuses and/or incentives to incentivize staff to pick up open shifts as well as various employment engagement retention events. DON and Staffing Coordinator will conduct daily staffing audits for 2 weeks, and then bi-weekly for 2 months. Results of these audits will be presented to the Administrator at the quarterly QAPI meeting, for review and revision as deemed appropriate.	

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S 560	Continued From page 2 day shift, required at least 15 CNAs. -06/18/21 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/18/21 had 10 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -06/19/21 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/20/21 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/21/21 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/22/21 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -06/23/21 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/24/21 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/25/21 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/26/21 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. For the 2 weeks of Complaint staffing from 12/19/2021 to 12/01/2022, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts and deficient in total staff for residents on 1 of 14 day shifts as follows: -12/19/21 had 11 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/20/21 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/21/21 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/24/21 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/25/21 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/25/21 had 9 total staff for 139 residents on	S 560		

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COMPLETE CARE AT CEDAR GROVE	536 RIDGE ROAD CEDAR GROVE, NJ 07009

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S 560	Continued From page 3 the overnight shift, required at least 10 total staff. -12/26/21 had 8 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/27/21 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/28/21 had 10 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/29/21 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -12/31/21 had 16 CNAs for 145 residents on the day shift, required at least 18 CNAs. -01/01/22 had 14 CNAs for 145 residents on the day shift, required at least 18 CNAs. For the 2 weeks of Complaint staffing from 01/09/2022 to 01/22/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/09/22 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/10/22 had 15 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/11/22 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/12/22 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/13/22 had 18 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/14/22 had 14 CNAs for 152 residents on the day shift, required at least 19 CNAs. -01/15/22 had 17 CNAs for 149 residents on the day shift, required at least 19 CNAs. -01/16/22 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/17/22 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/18/22 had 16 CNAs for 151 residents on the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060720	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	536 RIDGE 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 4 day shift, required at least 19 CNAs. -01/19/22 had 18 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/20/22 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/21/22 had 14 CNAs for 151 residents on the day shift, required at least 19 CNAs. -01/22/22 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs. For the 2 weeks of Complaint staffing from 02/06/2022 to 02/19/2022, the facility was deficient in CNA staffing for residents on12 of 14 day shifts as follows: -02/06/22 had 13 CNAs for 157 residents on the day shift, required at least 20 CNAs. -02/07/22 had 18 CNAs for 157 residents on the day shift, required at least 20 CNAs. -02/08/22 had 17 CNAs for 157 residents on the day shift, required at least 20 CNAs. -02/10/22 had 19 CNAs for 161 residents on the day shift, required at least 20 CNAs. -02/12/22 had 15 CNAs for 153 residents on the day shift, required at least 19 CNAs. -02/13/22 had 13 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/14/22 had 16 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/15/22 had 16 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/16/22 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/17/22 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/18/22 had 15 CNAs for 152 residents on the day shift, required at least 19 CNAs. -02/19/22 had 16 CNAs for 152 residents on the day shift, required at least 19 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060720	A. BUILDING: _____ B. WING _____	C 08/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	536 RIDGE 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 5 For the 2 weeks of staffing prior to survey from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -07/30/23 had 19 CNAs for 171 residents on the day shift, required at least 21 CNAs. -07/31/23 had 20 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/01/23 had 18 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/02/23 had 18 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/03/23 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs. -08/04/23 had 19 CNAs for 172 residents on the day shift, required at least 21 CNAs. -08/05/23 had 17 CNAs for 172 residents on the day shift, required at least 21 CNAs. -08/06/23 had 17 CNAs for 173 residents on the day shift, required at least 22 CNAs. -08/07/23 had 17 CNAs for 172 residents on the day shift, required at least 21 CNAs. -08/08/23 had 15 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/09/23 had 16 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/10/23 had 17 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/11/23 had 16 CNAs for 171 residents on the day shift, required at least 21 CNAs. -08/12/23 had 17 CNAs for 171 residents on the day shift, required at least 21 CNAs.	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
315216 Y1	A. Building B. Wing Y2	9/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	536 RIDGE 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 F0561	Correction	ID Prefix F0623	Correction	ID Prefix F0641	Correction
Reg. # 483.10(f)(1)-(3)(8)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(g)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
ID Prefix F0656	Correction	ID Prefix F0677	Correction	ID Prefix F0689	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
ID Prefix F0695	Correction	ID Prefix F0760	Correction	ID Prefix F0804	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.45(f)(2)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
ID Prefix F0809	Correction	ID Prefix F0812	Correction	ID Prefix F0868	Correction
Reg. # 483.60(f)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)	Completed
LSC	09/07/2023	LSC	09/07/2023	LSC	09/07/2023
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? ☐ YES ☐ NO
8/18/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060720 Y1	A. Building B. Wing Y2	9/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	536 RIDGE 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 09/07/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	**536 RIDGE 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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 08/18/23. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
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 08/18/23 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 Complete Care at Cedar Grove is a two-story building with a partial basement that was built in 1980's, It is composed of Type I protected construction. The facility is divided into 12 smoke zones. The generator powers 100 % of the building per the Maintenance Director. The number of occupied beds are 169 out of 188.	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced	K 225		9/29/23

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

Electronically Signed | 09/04/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 225	Continued From page 1 by: Based on observation and interview, the facility failed to maintain the one-hour fire resistance rating of stairways in accordance with NFPA 101 (2012 Edition) Section 7.2. This deficient practice had the potential to affect 100 residents. Findings include: An observation on 08/18/23 at 12:13 PM of the designated Exit Stairwell door in the basement corridor by the elevators revealed the door did not positive latch in the frame. The stairwell connected all three floor levels in the facility. The basement level housed common areas such as the dining room and Physical Therapy Room used by residents. An interview with the Maintenance Director and Administrator at the time of the observation confirmed the finding and revealed the facility was not aware the door was not latching prior to the observation. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 225	POC K 225 SMOKE enclosures Individual residents were not affected by this deficient practice, but all residents had the potential to be affected. Maintenance staff were educated as to exit stairwell doors needing to always positive latch in the frame. The basement exit stairwell door will be repaired by October 6, 2023, so that the door does positive latch in the frame. All Exit Stairwell doors were inspected for appropriate positive latching in the frame and will be checked by the Maintenance Director weekly for 3 months to ensure compliance. Results of the weekly audits will be shared with the Administrator at the quarterly QAPI meeting.	
K 353 SS=D	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.	K 353		9/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	**536 RIDGE ROAD** **CEDAR GROVE, NJ 07009**

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K 353	Continued From page 2 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 interview, the facility failed to maintain the sprinkler system free of foreign materials in the kitchen in accordance with NFPA 25 (2011 Edition). The deficient practice had the potential to affect all dining residents. Findings include: An observation on 08/18/23 at 12:46 PM of the sprinkler head in the walk-in freezer of the kitchen revealed the deflector was obstructed by ice buildup. AN interview with Maintenance Director at the time of the observation revealed the facility was unaware of the ice buildup prior to the observation. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	POC K 353 sprinkler system Individual residents were not affected by this deficient practice, but all residents had the potential to be affected. The maintenance staff were educated to immediately address any ice buildup on a sprinkler head. The ice buildup on the sprinkler head in the kitchen walk-in freezer was immediately removed and addressed on August 18. The Director of Maintenance will check all sprinkler heads throughout the kitchen area weekly for 3 months, to ensure there is no build-up of foreign materials or obstructions. Results of these audits will be shared with the Administrator at the quarterly QAPI meeting , with corrective actions initiated immediately when warranted.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier	K 372		9/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315216	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	**536 RIDGE ROAD** **CEDAR GROVE, NJ 07009**

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K 372	Continued From page 3 Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to maintain smoke barriers to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition), Section 8.5. This deficient practice had the potential to affect all residents. Findings include: 1. An observation on 08/18/23 at 10:45 AM of the smoke barrier at Room 211 revealed a two-inch unsealed gap along the top of the smoke wall in the rest room and two-inch gaps around pipe and duct penetrations above the corridor doors. 2. An observation on 08/18/23 at 11:05 AM of the smoke barrier at Room 253 revealed a two-inch unsealed gap along the top of the smoke wall on both sides of the wall, and a two-inch gap around two conduit penetrations above the mirror in the rest room of Room 253. There was also a two-inch gap around a conduit penetration above the corridor smoke doors by the shower room.	K 372	POC K372 smoke barrier doors Individual residents were not affected by this deficient practice, but all residents had the potential to be affected. Maintenance staff were educated regarding the requirements to address all penetrations utilizing the proper caulk item. All pipe and duct and conduit penetrations and gaps above the smoke walls will be thoroughly reviewed and addressed by utilizing red caulk, or other approved material. These areas include the following: smoke barriers at room 211, room 253, room 248, room 124, and near the one west secure unit. All other smoke doors will be checked as well. The fire- rated door by the kitchen which	

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K 372	Continued From page 4 3. An observation on 08/18/23 at 11:10 AM of the smoke barrier at Room 248 revealed a three-inch gap around a conduit penetration above the ceiling and mirror in the bathroom. 4. An observation on 08/18/23 at 11:45 AM of the smoke barrier by Room 124 revealed an unsealed two-inch gap around the duct penetration above the corridor doors and ceiling. 5. An observation on 08/18/23 at 11:50 AM of the smoke barrier at the entrance to the Memory Care Unit revealed three-inch gaps around unsealed conduit and pipe penetrations in the men's bathroom. 6. An observation on 08/18.23 at 12:49 PM of the rated wall in the basement corridor by the kitchen revealed the rated door had been removed. The floor plan provided by the facility indicated this was a rated fire door and part of the smoke barrier wall separating smoke compartments in the basement. The basement is used by residents for dining, activities, and Physical Therapy. A record review of the facility's "Fire Evacuation Plan" confirmed these unsealed gaps were located at smoke barriers that separate smoke compartments. Interviews conducted at the time of observations with the Maintenance Director and Administrator confirmed these unsealed gaps were located at smoke barriers that separate smoke compartments. NJAC 8:39-31.1(c), 31.2(e)	K 372	separates smoke compartments will be replaced by October 6, 2023. After all the above is repaired, the Director of Maintenance or his designee shall conduct a monthly audit of all smoke wall ceilings to assure that there are no gaps or penetrations, as well as a monthly audit of all fire rated doors to ensure they are in place and functioning appropriately. These 2 audits will continue for 6 months, and results will be shared with the Administrator at the quarterly QAPI meeting with immediate corrective actions to be implemented, if warranted.	

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	315216	A. BUILDING **01** B. WING _____	**08/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	**536 RIDGE ROAD** **CEDAR GROVE, NJ 07009**

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K 923	Continued From page 5	K 923		
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.	K 923		9/29/23

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COMPLETE CARE AT CEDAR GROVE	**536 RIDGE 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 923	Continued From page 6 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to meet the oxygen storage requirements of NFPA 99 (2012), Sections 11.6.2.3 and 11.3.2.3 by failing to store cylinders of compressed gas in a manner to prevent tipping and rupture and failing to maintain at least 5 feet of separation to combustible material. This deficient practice had the potential to affect all residents. Findings include: An observation on 08/18/23 at 11:20 AM of the Oxygen Storage Room revealed five E cylinders of oxygen were freestanding and not secured or protected from tipping and rupture. At the time of observation, a total of 76 E cylinders and 5 H cylinders were stored in the room. The room was 12 feet by 10 feet in size. Wood was observed within five feet of the H cylinders. An interview with the Maintenance Director and Administrator at the time of observation confirmed the findings. A review of the facility's" Oxygen In-service Training," dated 03/20/23, revealed staff were aware that oxygen cylinders were required to be put in the rack and not on the floor. NJAC 8:39-31.2(e) NFPA 99	K 923	POC K 923 oxygen All residents had the potential to be affected by this deficient practice, although no individual resident was identified. All of the free standing oxygen cylinders were placed in the proper holder , and the wood was removed from the room . Staff will be re-in serviced as to the protocol of always storing the oxygen tanks safely and securely in their proper rack/holder. The Director of Maintenance or his designee shall perform checks of the oxygen E and H cylinders in the oxygen room 3 times each week for 3 months, and document accordingly. Results of these audits will be presented to the Administrator at the quarterly QAPI meeting , for further follow-up if needed.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315216 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/29/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CEDAR GROVE	536 RIDGE 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 K0225	09/29/2023	LSC K0353	09/29/2023	LSC K0372	09/29/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	09/29/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO