

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315204	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025
NAME OF PROVIDER OR SUPPLIER CANTERBURY AT CEDAR GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 398 POMPTON AVENUE , CEDAR GROVE, New Jersey, 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
F0000	INITIAL COMMENTS Survey: Complaint Complaint Intake ID#: 2585781 Survey Dates: 11/12/25 to 11/13/25 Census: 135 Sample size: 3 The NJDOH conducted a Complaint Survey on 11/13/25. The survey was officially completed on 11/13/25. A Complaint Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		11/28/2025
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations	F0609	How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting Resident #1. The Administrator notified the Department of Health of the incident regarding Resident #1. NOTE Resident #1 is no longer in the facility. 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 the facility's failure to immediately report any injury of unknown origin. 3. What measures will be put in place or what systemic	12/11/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Continued from page 1 to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Complaint Intake ID #: 2585781</p> <p>Based on interview, record review, and review of facility documents on 11/12/25 and 11/13/25, it was determined that the facility failed to notify the New Jersey Department of Health (NJDOH) and the Office of the Ombudsman immediately or within two hours of the identification of NJ Ex Order 26.4(b)(1) in accordance with Federal and State laws and the facility's Abuse policy. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for abuse.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 11/12/25 at 10:50 AM, the surveyor reviewed the closed Electronic Medical Record (EMR) of Resident #1.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to; NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).</p> <p>A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated NJ Ex Order 26.4(b)(1), included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex which indicated that the resident was NJ Ex Order 26.4(b)(1). Further review of the MDS revealed that the resident received NJ Ex Order 26.4(b)(1) services.</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, initiated on NJ Ex Order 26.4(b)(1), with a revision date of NJ Ex Order 26.4(b)(1) included:</p> <p>Resident #1 is at risk for NJ Ex Order 26.4(b)(1) r/t (related to) their NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). Resident #1 has NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1). Interventions included: U.S. FOIA (b) (6) NJ Ex Order 26.4(b)(1) was DNR (do not return) pending investigation (initiated NJ Ex Order 26.4(b)(1)). Send to hospital for evaluation/tx (treatment) (initiated NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) daily and</p>		<p>Continued from page 1 changes will be made to ensure that the deficient practice will not recur?</p> <p>The U.S. FOIA (b) (6) was re-inserviced by the Director of Operations on 11/28/2025 on the requirements of any injury of unknown origin.</p> <p>NJ Ex The Administrator / designee will audit all incidents pertaining to suspected abuse to ensure they were called into the Department of Health within the appropriate amount of time monthly x3, quarterly thereafter.</p> <p>4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)</p> <p>The Administrator /designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.</p>	

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F0609 SS = D	<p>Continued from page 3 at 8:19 AM, revealed, At 6 AM, resident returned from ...hospital via [redacted] NJ Ex Order 26.4(b)(1) with no NJ Ex Order 26.4(b)(1) noted. Resident had [redacted] with [redacted] appear [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] observed...Resident was placed on a NJ Ex Order 26.4(b)(1)), bed to [redacted] MD and family [name redacted] made aware that resident is back to the facility. Resident will continue to be assisted with needs and monitored for [redacted]</p> <p>On 11/13/25 at 11:54 AM, the surveyor reviewed a Reportable Event Record/Report (RER/R) which indicated that a Significant Event was called into the NJDOH on [redacted] at 5:55 PM, for a Significant Event that occurred on [redacted] a 7:00 AM, 21 days later. Further review of the RER/R revealed that on [redacted] during morning rounds the resident was found to have a NJ Ex Order 26.4(b)(1) [redacted] ...</p> <p>Further review of the RER/R revealed that an ...Incident Investigation Summary included: During the investigation, a check of the environment immediately revealed the resident's newly acquired wheelchair footrests were visibly [redacted] NJ Ex Order 26.4(b)(1). The [redacted] was particularly noticeable on the attaching apparatus, the padding, and the overall structure of the footrests. The [redacted] U.S. FOIA conducted interviews with staff assigned to the resident between the time they received the new wheelchair to the time [redacted] noted. Staff reports the resident who typically spends most of their day in the day room for meals, activities, and [redacted] NJ Ex Order 26.4(b)(1), acquired a new wheelchair from hospice yesterday. Unlike their previous wheelchair, this one had leg rests. It was determined that [redacted] NJ Ex Order 26.4(b)(1) [redacted] occurred when the resident habitually stood up and stepped away from the table, [redacted] NJ Ex Order 26.4(b)(1) [redacted] the footrest. This is supported by [redacted] NJ Ex Order 26.4(b)(1) found on the footrest, including the [redacted] NJ Ex Order 26.4(b)(1) pads, and structure, as well as [redacted] NJ Ex Order 26.4(b)(1) on the lower plates, and of their [redacted] NJ Ex Order 26.4(b)(1).</p> <p>A review of the Timeline of Events included:</p> <p>[redacted] NJ Ex Order 26.4(b)(1) 7-3-Hospice aide gave [redacted] NJ Ex Order 26.4(b)(1), and the resident was in the dayroom where they ate lunch and dinner.</p> <p>[redacted] NJ Ex Order 26.4(b)(1) 3-11 [redacted] U.S. FOIA (b) (6) put resident in bed around 6:30 pm.</p>	F0609		

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F0609 SS = D	<p>Continued from page 4</p> <p>NJ Ex Order 26.4 11-7 U.S. FOIA check and change done.</p> <p>NJ Ex Order 26.4 7-3 NJ Ex Order 26.4(b) noted to resident's NJ Ex Order 26.4</p> <p>A review of an Investigation of Incident Statement dated NJ Ex Order 26.4, revealed that CNA #1 worked as a care partner on NJ Ex Order 26.4 during the 3-11 PM shift. The statement included that it was written by the U.S. FOIA and was copied from a text message sent by CNA #1. A review of the entry included: When providing care for patient after dinner another U.S. FOIA assisted me putting the patient into bed. Patient was not NJ Ex Order 26.4(b)(1), patient was wearing NJ Ex Order 26.4. Patient had their NJ Ex Order 26.4 on. I took their NJ Ex Order 26.4. During my shift I checked on patient multiple times, each time I found pt. in bed. At the end of my shift, I left pt. in bed NJ Ex Order 26.4(b)(1)</p> <p>On 11/12/25 at 1:21 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that she noted NJ Ex Order 26.4(b)(1) on the resident's NJ Ex Order 26.4(b)(1) during morning rounds and when the resident NJ Ex Order 26.4(b)(1) I saw that the resident had NJ Ex Order 26.4(b) with NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1). LPN #1 stated that it must have happened during the night or when NJ Ex Order 26.4(b)(1) and it was not endorsed to the night shift nurse. LPN #1 further stated that the resident had NJ Ex Order 26.4</p> <p>On 11/12/25 at 1:30 PM, the surveyor interviewed CNA #2 who worked full-time at the facility for NJ Ex Order 26.4 and had reportedly cared for the resident during the day shift. CNA #2 stated that she never saw NJ Ex Order 26.4 on the resident's NJ Ex Order 26.4 and if she did she would report any NJ Ex Order 26.4(b)(1) to the nurse.</p> <p>On 11/12/25 at 1:49 PM, the surveyor interviewed LPN #2 who stated that she worked on the 3-11 shift on the day that the NJ Ex Order 26.4(b) occurred, and she did not see anything on the resident's NJ Ex Order 26.4. LPN #2 stated that CNA #1 put the resident to bed and did not report anything to me. LPN #2 further stated that CNA #1 did not work here anymore.</p> <p>On 11/12/25 at 2:20 PM, the surveyor interviewed the U.S. FOIA and asked the U.S. FOIA if the NJ Ex Order 26.4(b) were donned (put on) and doffed (removed) as indicated on the MAR on NJ Ex Order 26.4 during both the day night shifts, why had staff not noticed the NJ Ex Order 26.4(b)(1) the resident's NJ Ex Order 26.4. The U.S. FOIA stated that if the NJ Ex Order 26.4(b) were on, the NJ Ex Order 26.4 was at the level of the resident's NJ Ex Order 26.4. The U.S. FOIA further stated, I do not think that they</p>	F0609		

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<p>F0609 SS = D</p>	<p>Continued from page 5 did it (donned and doffed the [redacted]) even though they signed it out as completed.</p> <p>At that time, the [redacted] stated that there was no written statement from CNA #1 because she was very [redacted] and [redacted] when approached via telephone about the resident's [redacted] and she did not give me a chance to obtain a written statement. The [redacted] stated CNA #1, "called me [redacted]" and then she showed up here and had to be escorted out of the building because she was beyond reproach. The [redacted] stated that it was CNA #1's personality problem, and she was terminated.</p> <p>At that time, the [redacted] stated, unfortunately, the resident [redacted], and no one noticed. The [redacted] further stated that any [redacted] should be called in to the NJDOH and Ombudsman's Office right away especially if the resident was not able to tell you what happened. The [redacted] stated that we did not call the [redacted] in because it only took one to two hours to determine that the [redacted] the wheelchair. The [redacted] stated that we reported it after surveyor inquiry during an onsite complaint investigation from the NJDOH in [redacted], because there was a little gray area of what happened. The [redacted] further stated, "Now I know that I should have just reported it immediately in hindsight."</p> <p>On 11/13/25 at 10:31 AM, the surveyor interviewed the [redacted] who stated that when an [redacted] occurred we first need to rule out [redacted]. The [redacted] stated that he was required to call the [redacted] in immediately or within two hours, and then the electronic submission must be sent within twenty-four hours and followed up with a summary and conclusion submission within five days. The [redacted] stated that the importance of reporting was because it was a required regulation, so that the NJDOH knows about it.</p> <p>At that time, the [redacted] stated that the reason why the resident's [redacted] was not called in was because there was [redacted] found on [redacted] of the resident's wheelchair footrest and [redacted] the resident's [redacted] was also on the equipment, and it was [redacted] what had happened. The [redacted] stated that he was aware of CNA #1's reaction when she was questioned about the incident, and he believed that CNA #1 felt accused when we requested a statement.</p> <p>A review of the facility's "Abuse, Neglect and Mistreatment of Residents" policy, reviewed 9/2025, included:</p>	<p>F0609</p>		

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F0609 SS = D	Continued from page 6 ...The Administrator and Director of Nursing will be made aware of all such incidents occurring in Facility and will review completed reports. If any accident is of a serious nature, medically or suspected abuse, neglect, telephone within 2 (two) hours regardless of the time of day. The Administrator/designee will ensure that staff directly involved will be suspended pending a complete investigation, depending on the circumstance of the incident. ...The Administrator/Designee will notify the Department of Health within two (2) hours... NJAC 8:39-9.4 (e) 4	F0609		

New Jersey State Department of Health

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S0000	Initial Comments Complaint Intake ID #: 2585781 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	S0000		11/28/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint Intake ID #: 2585781 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios, as mandated by the State of New Jersey. The facility was deficient in Certified Nursing Assistant (CNA) staffing for residents on 6 of 14 dayshifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "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 nursing homes. The following ratio(s) were effective on 02/01/2021:	S0560	How the corrective action will be accomplished for those residents found to be affected by this practice? Affecting all residents. The Administrator immediately contacted the recruiter to ensure all ads are optimized to the fullest. The Staffing Coordinator and team have weekly staffing phone calls ongoing in an effort to improve recruitment and retention. No care concerns were reported during the shifts indicated. 2. How the Facility will identify other residents having the potential to be affected by the same deficient practice? All Residents have the ability to be affected by the facility not meeting the requirements to maintain the required minimum direct care staff to resident ratios, as mandated by the State of New Jersey. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient	12/02/2025

Office of Primary Care and Health Systems Management

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S0560	<p>Continued from page 1</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift.</p> <p>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</p> <p>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.</p> <p>For the 2 weeks of Complaint staffing from 10/26/2025 to 11/08/2025, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows:</p> <p>-10/26/25 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs.</p> <p>-10/28/25 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs.</p> <p>-11/01/25 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs.</p> <p>-11/02/25 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs.</p> <p>-11/03/25 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs.</p> <p>-11/08/25 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs.</p> <p>On 11/13/25 at 10:21 AM, the surveyor interviewed the Staffing Coordinator (SC) and asked him if the facility was able to meet the required CNA to resident ratios, and the SC stated, "So far, so good."</p> <p>On 11/13/25 at 10:31 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he felt that the facility was doing pretty good with meeting the required CNA to resident ratios.</p> <p>A review of the facility's "Staffing" policy, reviewed 12/2024, included:</p> <p>It is the policy and procedure of this facility to adequately staff the facility in accordance with the NJ</p>	S0560	<p>Continued from page 1 practice will not recur?</p> <p>Staffing coordinator was re-inserviced by the Administrator on 11/28/2025 on the direct care staff to resident ratios.</p> <p>Agency contracts were reviewed to ensure the facility had outside resources in times of staffing shortages. Implemented a refer a friend incentive program as well as a sign on bonus.</p> <p>The staffing coordinator/designee will audit direct care staffing ratios to ensure it is within the requirements as mandated by the State of New Jersey, weekly x4, monthly x3 months, quarterly thereafter.</p> <p>4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, (e.g., what quality assurance program will be put into place?)</p> <p>The Staffing coordinator/designee will review any findings of these audits and present them quarterly with the QAPI committee to determine the frequency of future audits.</p>	

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S0560	Continued from page 2 State guidelines...	S0560		

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F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 12/12/2025 in relation to the 11/13/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060729	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER CANTERBURY AT CEDAR GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 398 POMPTON AVENUE , CEDAR GROVE, New Jersey, 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
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/12/2025 in relation to the 11/13/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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