STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 07/03/2024

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CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE 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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s: NJ174254, NJ174185, NJ173759, NJ172378, NJ169810, NJ168525, NJ167975, NJ166657, NJ166184, NJ165423, NJ165096, NJ164805, NJ162530, NJ159080 Survey Dates: 06/25/2024 through 07/03/2024 Census: 147 Sample Size: 29 + 3 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 550 SS=F	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		7/23/24

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

Electronically Signed | 07/25/2024

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure residents were served their meals in a dignified manner during meal services. This deficient practice was identified on 3 of 3	F 550	1. Corrective action/s (a) Dish washing machine was fixed on 7/23/24. (b) Kitchen discontinued the use of disposables on 7/4/24 and statrted using	

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F 550	Continued From page 2 nursing units on multiple dates of observation and was evidence by the following: 1. On 6/27/24 at 12:05 PM, this surveyor observed the lunch meal on the 4th floor. The main dining room had 18 residents. 18 of 18 residents were served their meal on NJ Ex Order 26.4(b)(1) plates and cups, with plastic utensils. The surveyor further observed the residents who were eating in their rooms also having NJ Ex Order 26.4(b)(1) plates and cups, with plastic utensils. The surveyor interviewed Certified Nursing Assistant (CNA #1), who stated that NJ Ex Order 26.4(b)(1) were used on most meals and it has been ongoing for the past 6 weeks. 2. 0n 6/28/24 at 8:20 AM, the surveyor observed the breakfast meal on the 2nd floor. All the residents on the unit were being served in their rooms and were observed with the use of NJ Ex Order 26.4(b)(1) plates and bowls with plastic utensils. 3. 0n 6/28/24 at 8:27 AM, the surveyor observed the breakfast meal on the 3rd floor. All the residents on the unit were being served in their rooms and were observed with the use of NJ Ex Order 26.4(b)(1) plates and bowls with plastic utensils. 4. 0n 6/28/24 at 8:33 AM, the surveyor observed the breakfast meal on the 4th floor. All the residents on the unit were being served in their rooms and were observed with the use of NJ Ex Order 26.4(b)(1) plates and bowls with plastic utensils. During the resident council meeting conducted during the survey period where 5 residents in the facility attended. There were 5 of 5 residents who stated that the meals were served on "Disposable containers, plates, and utensils for a couple	F 550	china plates and metal utensils on 7/4/24 2. Residents with potentials to be affected. (a) All residents could potentially be affected by deficient practice 3. Systemic change to ensure deficient practice does not recur. (a) Food services director was inserviced by the administrator to monitor equipment closely to identify any signs of potential break down and to notify maintenance director immediately. (b) US FOIA (b)(6) was in-serviced to inspect equipment immediately when asked by Dietary director and to notify administrator immediately if parts are needed or if replacement is recommended. (c) NJ Ex Order 26.4b1 (vendor) will be required to carry out periodic inspection of equipment and to advice proactively when new parts or replacement is needed. 4. How to monitor corrective measures (a) Dietary director will monitor equipment daily for signs of malfunction or unusual sound. (b) Maintenance director will inspect equipment weekly for 4 weeks, bi- weekly for 4 weeks and monthly continuously, with a view to detecting problems before they occur. (c) Dietary director to monitor trays, 3 times	

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F 550	Continued From page 3 months and would prefer regular China and utensils." The same 5 of 5 residents further stated that they were informed by the dietary department the dish machine in the facility was broken. On 6/28/24 at 09:34 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who confirmed the dish machine has not worked for the last 5 or 6 weeks. The U.S. FOIA further stated, he had made frequent requests to the management to have the dish machine fixed. The surveyor further asked why the dietary department was unable to serve meals with non-disposable plates, utensils and glassware while utilizing the three compartment sink (three sink method is the manual procedure for cleaning and sanitizing dishes in commercial settings) for cleaning and sanitizing the dishes, cups utensils and other cookware, the U.S. FOIA stated, "they are trying to use as much non-disposable plates and such but with the size of the resident population, it's very difficult to stay on track with regards to meal preparation." On 6/28/24 at 10:12 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated he has sent multiple emails to corporate regarding the dish machine repair. Tha U.S. FOIA (b) also agreed the residents should not be eating meals off disposable plates and plastic cutlery. A review of the facility's Resident Rights policy with a revised date of 11/2023 stated under the Resident Rights Acknowledgment section, 1. "Resident rights, The resident has the right to a dignified existence ...5. Respect and dignity; c. The right to side and receive services in the	F 550	5. Result of monitoring will be reviewed at quarterly QAPI	

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F 550	Continued From page 4 facility with reasonable accommodation of resident needs and preferences ....6. Self-determination, b. The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident." On 7/1/24 at 10:40 AM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6). The U.S. FOIA (b) provided copies of emails sent to corporate regarding the dish machine. The U.S. FOIA (b) further stated the dish machine was being replaced today 7/1/24. No further information was provided. N.J.A.C. 8:39-27.1(a)	F 550		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with	F 577		7/21/24

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F 577	Continued From page 5 respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain the prior year's state of New Jersey inspection results and post the location of those results in an area that was readily accessible to residents, families and the general public. This deficient practice was evidenced by the following: On 6/27/24 at 10:47 AM, the surveyor conducted a group meeting with seven (7) residents in attendance, Resident #5, Resident #20, Resident #43, Resident #96, Resident #118, Resident #128 and Resident #199. When asked if they were aware of the location of the previous year's survey inspection report, 7 residents said no. On 06/27/24 from 10:47 AM until 11:54 AM, the surveyor conducted the resident council meeting with seven (7) facility chosen residents who regularly attend the facility's resident council meetings that were conducted monthly. The surveyor asked if they know where the results of previous Department of Health surveys were available to them if they would like to read them, all 7 of 7 residents (Resident #5, Resident #20, Resident #43, Resident #96, Resident #118,	F 577	Corrective action: (a) Signs informing residents, visitors and staff that survey results are available at the nursing stations and front desk were posted in the elevators, entrance, and nursing stations by the administrator on 6/28/24 (b)Activities staff were re-educated by Activity director on the need to discuss locations of Survey results at every resident council meeting on 6/28/24 Residents with potentials to be affected by the deficient practice. (a) All residents can potentially be affected by deficient practice Systemic change/s to ensure deficient practice does not recur (a) Activity director or designee will continue to inform residents of the locations of the survey result during monthly residents' council meeting. (b) Activity director or designee will inform residents of the location once a week during residents' group activities.	

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F 577	Continued From page 6 Resident #128, and Resident #199) responded they did not know where the prior survey results were located. The surveyor reviewed the resident council minutes dated 6/3/2024. The seventh item that was reviewed revealed: "Residents were reminded that the current Department of Health Survey Results is located in the front lobby. Any questions to be directed to the U.S. FOIA (b) (6) This item was noted to have the Staff Initials [redacted] next to it. The surveyor did not observe any signs regarding the survey results on any of the nursing units or in the elevators. On 06/28/24 at 10:41 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the survey binder that had the survey results was at the front desk and at each nursing station and should be presented to a resident if the resident would request for it. The [redacted] further stated that the facility's U.S. FOIA (b) (6) [redacted] was in charge of the survey binder. On 06/28/24 at 10:53 AM, the surveyor interviewed the U.S. FOIA (b) (6) of the third floor who stated the survey results were downstairs at the front desk. On 06/28/24 at 10:57, the surveyor interviewed the [redacted] who stated there is a book at the front desk with the survey results in it. He further stated that the location of the book was discussed with the residents upon admission. He also stated that there should have been signs at each nurse's station and at the entrance by the front desk.	F 577	How to monitor corrective action. (a) Administrator/designee to ensure that information about location of survey result is in every resident council meeting before signing. (b) Administrator/designee will conduct rounds, weekly for 4 weeks, by weekly for 8 eight weeks to ensure that posted signs are still in place. (c) Activity director/designee will conduct audit interview of residents, once weekly for 4 weeks, bi-weekly for 4 weeks and monthly for 3 months, to test their knowledge of locations of the survey results. Results of audit/monitoring will be submitted to quarterly QAPI committee meeting review, revision or termination.	

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F 577	Continued From page 7 On 06/28/24 at 11:00 AM the surveyor observed a binder at the front desk, spine facing outward. Front of book labeled "Survey Book Vol.11". The spine of the binder with the original item/brand sticker. On 6/28/24 at 1:26 PM, the surveyor spoke with the facility's U.S. FOIA (b) (6), U.S. FOIA (b) (6) [redacted] and the U.S. FOIA (b) (6) [redacted]. The surveyor informed them regarding the concern of the most recent state survey inspection report not being available for residents, families, and the general public in an area that was easily accessible, where they wouldn't have to ask someone for them and signage directing them to the location of said results. On 07/01/24 at 11:08 AM the U.S. FOIA (b) [redacted] stated the facility does not have a policy regarding the survey results. He further stated that signs (indicating location of survey results binder) are now posted at the front reception, in the elevators and at each nurse's station. He also stated that the signs should've been posted all along. No further information was provided.	F 577		
F 609 SS=D	N.J.A.C. 8:39-9.4(b) 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	F 609		7/21/24

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F 609	Continued From page 8 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 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. This REQUIREMENT is not met as evidenced by: Complaint #: NJ159080 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) within 2 hours for an allegation of a NJ Ex Order 26.4(b)(1) [redacted]. This deficient practice was identified for 1 of 5 investigations of reportable incidents reviewed (Resident #36, #299). This deficient practice was evidenced by the following:	F 609	Corrective action/s (a) All facility staff were educate on timely reporting of allegation of abuse, neglect, exploitation, mistreatment, exploitation and misappropriation of residents' property by the administrator and evening supervisor on 6/28/24. Report alegagtion immediately to your manager or supervisor if manager is not present or during weekends. (b) Management staff were in-serviced by the Administrator to report immediately to Administrator, DON or ADON immediately	

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F 609	Continued From page 9 1. On 6/25/24 at 1:21 PM, the surveyor reviewed a form titled "Reportable Event Record/Report Form" which involved Resident #36 and Resident #299. The form was dated NJ Ex Order 26.4(b) and documented an event that occurred on NJ Ex Order 26.4(b) at 9:00 PM involving Resident #36 and Resident #299. The report documented Resident #299 was observed by the staff NJ Ex Order 26. Resident #36 and was NJ Ex Order 26.4(b)(1). The residents were NJ Ex Order 26.4(b)(1) immediately by the staff who witnessed the incident. The report concluded, "Based on witness statement and both residents account, Resident #299 NJ Ex Order 26.4(b) Resident #36 by NJ Ex Order 26 while trying to NJ Ex Order 26.4(b)(1). Resident #299 on the other hand was NJ Ex Order 26.4(b)(by Resident #36's attempt to NJ Ex Order 26.4(b)(1) . Resident #299 escalated the NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1)." Resident #299 was immediately transferred to the hospital and Resident #36 was transferred to a different unit. A review of Resident #36's Admission Record (an admission summary) (AR) indicated the resident was admitted to the facility with diagnoses that included but was not limited to NJ Ex Order 26.4(b)(1) A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 2 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15 which indicated that the resident had NJ Ex Order 26.4(b)(1) A review of Resident #36's interdisciplinary care plan with a revision date of NJ Ex Order 26.4(b) included a care plan titled, " The resident has potential to demonstrate NJ Ex Order 26.4(b)(1) ..."	F 609	they receive report of allegation of abuse from their staff on 6/28/24. Residents with potentials to be affected. (a) All residents can potentially be affected by deficient practice. Systemic change to ensure deficient practice does not recur. (a) Administrator/designee will be responsible for reviewing facility policy on Abuse, Neglect and Exploitation during new hire general orientation. How to monitor corrective action (a) Human resources/designee will review new hire employee folders by-weekly for 4 weeks and monthly for 3 months to ensure that abuse policy was signed by employee upon hire (b) All department heads/designee will conduct monthly audit of employee knowledge of reporting process for 3 months. Result of audit/monitoring will be submitted to quartely QAPI for review, revision or termination.	

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F 609	Continued From page 10 A review of Resident #229's AR indicated the resident was admitted to the facility with diagnoses that included but was not limited to NJ Ex Order 26.4(b)(1). Further review of the resident's hybrid medical record revealed that the resident [redacted] in the facility on [redacted]. A review of the Q/MDS an assessment tool used to facilitate the management of care, dated [redacted] reflected that the BIMS score was not obtained due to NJ Ex Order 26.4(b)(1). A review of Resident #299's interdisciplinary care plan with a revision date of [redacted] included a care plan titled, " [Resident #299] has potential to demonstrate NJ Ex Order 26.4(b)(1) related to diagnosis of NJ Ex Order 26.4(b)(1) [redacted] ..." On 6/28/2024 at 1:33 PM, the surveyor interviewed the facility's U.S. FOIA (b) (6) [redacted]) who confirmed the details of the incident that took place on, [redacted]. The [redacted] stated the incident "happened on a weekend" and the "Reportable Event Record/Report Form" was not reported to the NJDOH until Monday, [redacted]. The facility could not provide any documentation of the NJ Ex Order 26.4(b)(1) incident being reported within 2 hours to the NJDOH. A review of the provided facility policy titled, "Abuse, Neglect and Exploitation" which documented under Policy Explanation and Compliance Guidelines: "VII.	F 609		

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F 609	Continued From page 11 Reporting/Response.. A. 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later thatn 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." On 7/1/24 at 10:44AM, the surveyor informed the facility's U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6) regarding the above concern. The U.S. FOIA (b) acknowledged the reportable event was not reported to the NJDOH in a timely manner according to federal and state regulations. There was no further information provided by the facility.	F 609		
F 641 SS=D	N.J.A.C. 8:39-5.1(a) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with the federal guidelines for 2 of 29 residents (Resident #16, and Resident #7) reviewed for the accuracy	F 641	On 7/2/24 Resident #16, #7 were immediately assessed for NJ Ex Order 26.4(b)(1) NJ Ex effects noted. Minimum Data Set assessment was modified and submitted on 7/2/24 for Section NJ Ex Order 26.4(under Section to reflect the resident□s behaviors noted during the look back	7/23/24

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F 641	Continued From page 12 of MDS completion. The deficient practice was evidenced by the following: 1. On 06/25/24, at 10:45 AM, the surveyor observed Resident #16 lying in bed with their eyes closed. On 06/25/24 at 12:45 PM, the surveyor reviewed Resident #16's hybrid (paper and electronic) medical record, which revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #16 was admitted to the facility with diagnoses that included but were not limited to [NJ Ex Order 26.4(b)(1)] [redacted] A review of the Quarterly MDS (Q/MDS), dated [NJ Ex Order 26.4] [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex] out of 15, indicating that the resident had [NJ Ex Order 26] [redacted] Further review of the Q/MDS "Section [NJ Ex Order 26.4] [redacted]" under Section D0150 Resident [NJ Ex Order] [redacted] Interview (PHQ-2-9) which reflected that the interview was conducted and signed on [NJ Ex Order 26.4] [redacted], three (3) days before the Assessment Reference Date (ARD) (refers to a specific endpoint for the observation period in the MDS assessment process). A review of the [NJ Ex Order 26.4(b)(1)] [redacted] electronic Medication Administration Record (eMAR) revealed a physician's order which indicated, "Resident is on ([NJ Ex Order 26] [redacted] for indication of [NJ Ex Order 26.4(b)(1)] [redacted]) for ([NJ Ex Order 26.4(b)(1)] [redacted] every shift Target behavior observed of [NJ Ex Order 26.4(b)(1)] [redacted],	F 641	period prior to submitting. U.S. FOIA (b) (6) [redacted] and the Licensed Social Workers were in-service on accuracy of MDS coding and assessments by the Regional Clinical Reimbursement Coordinator on 7/2/24 to make sure that MDS assessments are based on documentation, demonstration, staff interviews and will reflect any significant changes or behaviors that were observed during the look-back period prior to submitting the MDS. 2. All facility residents require a comprehensive MDS and therefore have the potential to be affected by deficient practice. 3. All current facility residents with behaviors will be checked for proper assessments and MDS coding. MDS/Designee will follow policy and procedures on completing quarterly, annual and significant change MDSs if any, including timely assessments and right MDS coding for behaviors. Regional MDS/Designee will continue in-services for MDS staff on facility policy and procedures on MDS completion, including correct coding for behaviors. 4. Minimum Data Set Coordinator or designee will conduct audits for all residents with behaviors to ensure that all have proper MDS coding; the audits will be completed weekly for four weeks, every two weeks for two months and monthly for 3 months on MDS	

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F 641	Continued From page 13 NJ Ex Order 26.4(b)(1)." The listed behaviors were observed on NJ Ex Order 26.4, NJ Ex O and NJ Ex, NJ Ex Order as indicated in the eMAR. A review of the NJ Ex Order 26.4 Q/MDS for "Section E Behavior" under Section E0200A - Presence and Frequency reflected "0. Behavior not exhibited." which indicated the behaviors that were observed during the look-back period did not reflect in the Q/MDS, which was 7 days before to the ARD. 2. On 06/25/24, at 10:45 AM, the surveyor observed Resident #7 in bed awake, NJ Ex Orde and NJ Ex Order 26.4(b NJ Ex Or to answer the surveyor's inquiry. On 06/28/24 at 12:20 PM, the surveyor reviewed Resident #7's hybrid (paper and electronic) medical record, which revealed the following information: A review of Resident #7's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) . A review of the Annual MDS (A/MDS), dated NJ Ex Order 26.4, reflected that the resident had a BIMS score of NJ Ex out of 15, indicating that the resident had NJ Ex Order 26.4(b)(1). Further review of the Q/MDS "Section NJ Ex Order 26.4" under Section D0150 Resident Mood Interview (PHQ-2-9), which reflected that the interview was conducted and signed on NJ Ex Order 26.4, three (3) days before the ARD. On 6/28/24 at 9:40 AM, the surveyor interviewed the facility's U.S. FOIA (b) (6)), who was responsible for completing Section NJ and Section E in the MDS assessments. The U.S. FO stated that	F 641	Assessments to ensure accuracy of the MDS coding reflects the noted changes or behaviors prior to submitting. The Administrator and/or Designee will be responsible for monitoring audit completion. Results of all audits will be presented to the monthly QAPI (Quality Assurance Performance Improvement) Committee for three months.	

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F 641	Continued From page 14	F 641		

he had been interviewing the residents for Section [NJ] screening at least 2-3 days before the ARD. The [U.S. FO] also confirmed that the lookback period to complete Section [NJ] must be 14 days before the ARD. The [U.S. FO] did not provide any further information as to why he was doing the interview before the indicated ARD.

The [U.S. FO] added that Resident #16's behavior, documented in the [NJ Ex Order 26.4(b)(1)] eMAR, should have been coded under Section [redacted].

On 6/28/24 at 9:06 AM, the surveyor interviewed the U.S. FOIA (b) (6) [redacted]), who stated that the Section [NJ Ex Order 26.4] interview completed by the [U.S. FO] should have been a 14-day look-back period from the date of the ARD. The [U.S. FOIA (b) (6)] added that they followed the Resident Assessment Instrument (RAI) Manual.

The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) RAI Version 3.0 Manual, updated October 2023. The RAI manual revealed under Chapter 3, page D-2, " .... This interview is conducted during the look-back period of the Assessment Reference Date ...." Further review under Chapter 3 Section E0200 Behavioral Symptom - Presence and Frequency, page E-5 reflected .... "1. Review the medical record for the 7-day look-back period."

On 6/28/24 at 12:30 PM, the survey team met with the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6), U.S. FOIA (b) (6) [redacted], and U.S. FOIA (b) (6) [redacted]. No further information was provided.

NJAC 8:39-33.2(d)

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a resident's comprehensive care plan (CP) to include [redacted]. This deficient practice was identified for 1 of 29 residents reviewed for resident-centered care plans (Resident #350), and was evidenced by the following:	F 657	1. Corrective action/measure (a) Resident #350 had [redacted] due to the alleged deficient practice. 6/27/24 [redacted] Care Plan was revised to reflect the residents plan of care in the electronic medical records. (b) 6/27/2024 A facility house audit was completed for all smoking residents to	7/23/24

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F 657	Continued From page 16 The Admission Record (AR) indicated that Resident #350 was admitted to the facility with the diagnoses which included but was not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The Admission Minimum Data Set (A/MDS), an assessment tool that facilitates resident care, dated NJ Ex Order 26.4(b) reflected that the resident was NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26.4(b)(1) with activities of daily living. On 06/26/24 at 10:52 AM, the surveyor interviewed Resident #350 who was NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). The resident stated that they had been in the facility for approximately NJ Ex Order 26.4(b)(1). Resident #350 stated they enjoyed the recreation department and liked to attend the activities that the facility provided. The resident indicated that they had NJ Ex Order 26.4(b) and that NJ Ex Order 26.4(b) was permitted in a designated areas. The resident stated that the facility had a NJ Ex Order 26.4(b) schedule wherein residents were permitted to NJ Ex Order 26 at 09:30 AM, 01:15 PM, 04:15 PM, and 05:30 PM. The resident further stated that the staff held the NJ Ex Order 26.4(b)(1) NJ Ex Order 2 and NJ Ex Order 26.4 when not in use. The resident further stated that the staff monitors the NJ Ex Order 26.4(b) during the scheduled NJ Ex Order 26.4(b) times. Resident #350 stated the facility performed a NJ Ex Order 26.4(b) assessment to ensure that the resident was a NJ Ex Order 26.4(b)(1). The resident stated that they started NJ Ex Order 26.4(b) soon after being admitted to the facility. The surveyor reviewed the form titled, "Smoking Contact" and "Smoking Assessment" for Resident #350 dated NJ Ex Order 26.4(b), which revealed that Resident #350 required NJ Ex Order 26.4(b)(1) during NJ Ex Order 26.4(b) and there was a CP initiated for NJ Ex Or	F 657	include smoking assessment and a smoking care plan and were all in place at the time of the audit. 2. Residents with potentials to be affected by alleged deficient practice.Element 2: (a) All residents that reside in the facility have the potential to be affected by this deficient practice. 3. Systemic change to ensure alleged deficient practice (a) Director of Nursing (DON/Designee in-service the License nursing staff, Unit Managers, US FOIA (b)(6), and US FOIA (b)(6) on the facility policy and procedure for Smoking and initiating/revising a Comprehensive Care Plan on 6/27/2024 Care Plans will immediately be addressed upon changes, quarterly assessment, and annual assessment. 4. How to monitor measures (a) Audits will be monitored by the Director of Nursing/Unit Managers/ Facility Educator/Designee for initiating and revisions of care plans. (b) Five charts will be audited weekly for four weeks and then every two weeks for two months and then monthly for three months. 5. The audit results will be presented at the monthly QAPI meeting for review and revision as appropriate. Adverse findings will be addressed immediately, and trends will be reported to Quality Assurance and Performance Improvement Committee at	

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F 657	Continued From page 17 The surveyor reviewed Resident #350's list of CP and there was no documentation that a CP was implemented for NJ Ex Order 26.4(b)(1). Progress notes reflected the following: On NJ Ex Order 26.4b1 at 16:52 (04:52 PM) Smoking and Safety status "Resident uses NJ Ex Order 26.4(b)(1) " On 06/27/24 at 09:27 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who explained that when a resident was admitted to the facility, the nurse was responsible to complete the NJ Ex Order 26.4(assessment upon admission. The U.S. FOIA further stated that it would be important to complete the assessment immediately to ensure that the resident was safe to use a NJ Ex Order 26.4(b)(1), and also for the resident to have the right protective equipment such as a smoking apron. The U.S. FOIA added that it would be important to ensure the CP was implemented to include NJ Ex Order 26.4b1 with safety interventions. The U.S. FOIA added that the CP was a communication tool which provided information on how to care for a resident. On 06/27/24 at 09:45 AM, the surveyor interviewed the U.S. FOIA (b) (6) on the third floor who explained that when a resident was admitted to the facility and were a smoker, the NJ Ex Order 26.4(assessment must be completed upon admission. The U.S. FOIA (b) (6) stated that the NJ Ex Order 26.4(assessment must be completed so that the resident who NJ Ex Order 26.4 had the proper interventions in place to ensure safety and to determine if the resident was an independent smoker. The U.S. FOIA (b) (6) confirmed that a CP must	F 657	least quarterly.	

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be implemented to include that the resident smoked and had the proper safety interventions.

On 06/27/24 at 09:51 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who had been employed in the facility for 10 years. The U.S. FOIA stated that Resident #350 went out to smoke with supervision of the staff from activities department. The U.S. FOIA added that there had been no incidents or accidents reported regarding the resident NJ Ex Order 26.4(b)

On 06/27/24 at 09:55 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) on the first floor who had been employed in the facility for NJ Ex Order 26.4b1. LPN/UM #1 explained that if a resident NJ Ex Order 26.4(b) a physician's order must be obtained, and a NJ Ex Order 26.4(b) assessment must be completed upon admission to the facility. The LPN/UM#1 further explained that a NJ Ex Order 26.4(b) assessment was a functionality test to ensure that the resident could hold a cigarette safely as well as light the cigarette. She stated that it would be important to complete the assessment at the time the resident indicated that they smoked to ensure safety to the resident. LPN/UM #1 stated that the NJ Ex Order 26.4(b) assessment would be important to complete in order to determine if protective devices such as a protective apron, would be implemented to prevent the resident from being burnt. She confirmed that a CP would also have to be completed with NJ Ex Order 26.4(b)(1) interventions. The assessment included what CP interventions must be in place. She confirmed that the CP should have been implemented to include NJ Ex Ord [redacted] for Resident #350.

On 06/27/24 at 10:06 AM, the surveyor

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interviewed the LPN/UM #2 on the second floor. LPN/UM #2 stated that a smoking assessment must be completed to determine if a resident were [redacted] to [redacted] and if any interventions should be implemented to ensure that the resident was safe during [redacted] times. She stated that a CP must be initiated for [redacted] with interventions. LPN/UM #2 reviewed Resident 350's CP in the presence of the surveyor and confirmed that a CP was not implemented for [redacted] when the [redacted] assessment was completed on [redacted].

On 06/27/24 at 10:17 AM, the surveyor interviewed the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) who both agreed that when a [redacted] assessment was completed on [redacted], a CP should have been implemented to include that the resident [redacted]

A review of the the facility's policy titled, "Smoking" dated 02/01/2024 indicated that documentation to support decision making will be included in the medical record, including but not limited to:
-Resident wishes, or those of the representative.
-Assessment of relevant functional and cognitive behaviors affecting ability to smoke safely.
-Response to smoking cessation interventions.
-Compliance with smoking policy.

A review of the facility's policy titled, "Comprehensive Care Plans" dated 09/2023, indicated that "person-centered care" means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. The CP's policy reflected that the comprehensive CP would describe any specialized services the nursing

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F 657	Continued From page 20 would provide and would include measurable objectives and timeframe to meet the resident's needs and identified. The policy also indicated that qualified staff responsible for carrying out interventions specified in the CP would be notified of their roles and responsibilities for carrying out the interventions and when changes were made. On 7/1/24 at 10:44 AM, the survey team met with the U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6), and U.S. FOIA (b) (6) and discussed the above concern. No further information was provided. NJAC 8:39-11.2(i)	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to maintain professional standards of clinical practice for 3 of 29 residents reviewed by a.) not accurately documenting in the electronic Medication Administration Record (eMAR) according to the physician's order (PO) for Resident #46 b.) not obtaining a PO for a resident's NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted] for Resident #101, #146.	F 658	1. Corrective action/measures (a) Resident #46 had NJ Ex Order 26.4(b)(1) [redacted] due to the alleged deficient practice. Primary physician was made aware with a new order for NJ Ex Order 26.4b1 [redacted] on NJ Ex Order 26.4 [redacted]. (b) Resident #101 and Resident #146 had NJ Ex Order 26.4(b)(1) due to the alleged deficient practice. (c) The physician was made aware with a new order for NJ Ex Order 26.4(b)(1) status on NJ Ex Order 26.4 which is reflected in the resident□s	7/23/24

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F 658	Continued From page 21 This deficient practice was evidenced by: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." a-1.) On 06/26/24 at 11:06 AM, the surveyor observed Resident #46 in bed. The resident stated they were missing their NJ Ex Order 26.4(b)(1) [redacted] and that staff was aware. The resident further stated It has been missing for about NJ [redacted]. The resident told the surveyor that staff was aware and so was the U.S. FOIA (b) (6) The surveyor reviewed the electronic Medical	F 658	electronic medical record. (d) Resident #45 had NJ Ex Order 26.4(b)(1) [redacted] due to the alleged deficient practice. (e)The primary physician was made aware, and a new order was transcribed as per physician orders on 7/1/24. (f) NJ Ex Order 26.4(b)(1) A facility-wide audit was completed with residents' NJ Ex Order 26.4(b)(1) updated and reflected in the residents' electronic medical records. (g) 6/28/24 The facility performed a full-house audit with residents who require assistive devices. 2. Residents with potentials to be affected by the alleged deficient practice. (a) All residents that reside in the facility have the potential to be affected by this deficient practice. 3. Systemic changes to ensure alleged deficient practice does not recur (a) 6/28/24 DON/Designee In-service the License nursing Staff on the facility policy and procedure for Medication Administration. License nursing staff will review the medication administration record to identify the route for medication administration. (b) 6/28/24 DON/Designee in-service the License Staff/ Social Services/ Dietary/ Therapy on Use of Assistive Devices. The teams will work together to ensure availability of devices, ordering or replacing. (c) Director of Nursing /license nursing staff will monitor use of device, document refusal or problems in the electronic medical records.	

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F 658	Continued From page 22 Record for Resident #46. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). A review of the Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated NJ Ex Order 26.4(b) revealed the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15, indicating the resident was NJ Ex Order 26.4(b)(1). A review of the resident's Care plan revealed a focus titled,: "Risk for NJ Ex Order 26.4(b)(1) r/t (related to) NJ Ex Order 26.4(b)(1), Date Initiated: NJ Ex Order 26.4(b)(1)." Further review revealed: "Intervention: Ensure NJ Ex Order 26.4(b)(1) are NJ Ex Order 26 while awake and put NJ Ex Order 26.4(b)(at night, Date Initiated: NJ Ex Order 26.4(b)(1)" A review of the Physician Order Summary revealed a PO for: "NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) ON in AM and OFF in PM NJ Ex Or for NJ Ex Order 26.4(and NJ Ex Orc for NJ Ex Order 26 . every day and night shift for NJ Ex Order 26.4(b)(1), dated NJ Ex Order 26.4(b)(1). A review of the facility provided form titled, "Grievance Form" dated NJ Ex Order 26. for Resident #46 revealed: "Summary of Concern: The resident reported that NJ Ex Order 26.4(b)(1) is missing and that it is the NJ Ex Order 26.4(b)(1)." Further review revealed: "Resolution: The resident and family have been notified of all the facility's attempt to locate the NJ Ex Order 26.4(b)(1). Insurance was contacted for NJ Ex Order 26.4(b)(1)	F 658	4. How to monitor corrective measures (a) Audits will be monitored by the Director of Nursing/Unit Managers/ Designee for initiating physician orders and care plan for Code status in the residents electronic medical records. 10 charts will be audited weekly for four weeks and then every two weeks for two months and then monthly for three months. (b) The Unit Mangers/Designee will audit 5 charts weekly for four weeks and then every two weeks for two months and then monthly for three months for residents that require usage of assistive device. 5. The audit results will be presented at the monthly QAPI meeting for review and revision as appropriate. Adverse findings will be addressed immediately, and trends will be reported to Quality Assurance and Performance Improvement Committee at	

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A review of progress notes revealed a Health Status Note dated [redacted] at 16:35 (4:35 PM) "Note Text: Searched for reported [redacted] in the resident's room and around roommate's comer as requested, and non-found. [Name redacted] made aware of the comprehensive search. Also, the [redacted] completed another search on her own of the resident's room and the roommate. And was not able to locate. [redacted] searched as well of the laundry area and could not find the missing hearing aid. [name redacted] denied taking the hearing aid to her [redacted] facility however, [redacted] center will be contacted to check for the device in their facility."

A review of the eMAR revealed a Chart codes/follow up code which indicated, "a check symbol =administered"; "5 = Hold/see Nurse Notes; "9 = Other/See Nurse notes.

A review of the [redacted] eMAR's revealed a check for [redacted] night, a 9 for [redacted] day shift and a x for [redacted] night, [redacted] day and night shift.

A review of the [redacted] eMAR's revealed checks for day and night shifts except for [redacted] there was a 9 for day shift; [redacted] and [redacted] there was a 5 for day shift.

A review of the progress notes for the above eMAR documentation revealed the following progress notes:
-"[redacted] 11:14 eMAR - Medication Administration Note
Note Text: NJ Ex Order 26.4(b)(1) ON in AM and OFF in PM
[redacted] and [redacted].

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every day and night shift for NJ Ex Order 26.4(b)(1)

+ NJ Ex Order 26.4(b)(1) 10:30 eMAR - Medication Administration Note
Note Text: RESIDENT HAS NJ Ex Order 26.4(b)(1)

NJ Ex Order 26.4(b)(1) 11:50 eMar - Medication Administration Note
Note Text: NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) ON in AM and OFF in PM
NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). every day and night shift for NJ Ex Order 26.4(b)(1)."

Further review of the progress notes for NJ Ex Order 26 did not reveal any additional documentation regarding the NJ Ex O

A review of NJ Ex Order 26.4(b)(1) eMAR's revealed checks for day and night shifts for the entire month.

A review of the progress notes for NJ Ex Order 26.4(b)(1) did not reveal any documentation regarding the NJ Ex O

A review of the NJ Ex Order 26.4(b)(1) eMAR's revealed checks for day and night shifts except for the NJ Ex Order 26 there was a 5 for the day shift.

A review of the progress notes for the above eMAR documentation revealed a note: "NJ Ex Order 26.4(b)(1) 12:32 eMar - Medication Administration Note, Note Text: NJ Ex Order 26.4b1 after x3 attempts." Further review did not reveal any additional documentation regarding the NJ Ex Order 26.4(b)(1)

A review of the NJ Ex Order 26.4(b)(1) eMAR's revealed checks for day and night shifts except for NJ Ex Order 26 there was a 9 for day shift, NJ Ex Order 26.4(was blank for

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day shift, NJ Ex Order 26.4 & NJ Ex Order 26.4(there was a 9 for day shifts.

A review of the progress notes for the above eMAR documentation revealed the following notes:
-'NJ Ex Order 26.4(b)(1) 11:43 eMar - Medication Administration Note
Note Text: NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) ON in AM and OFF in PM
NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). every day and night shift for NJ Ex Order 26.4(b)(1), awaiting insurance approval
-NJ Ex Order 26.4(b)(1) 13:25 eMar - Medication Administration Note
Note Text: NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) ON in AM and OFF in PM
NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). every day and night shift for NJ Ex Order 26.4(b)(1)."

Further review did not reveal any additional documentation regarding the NJ Ex O

On 06/28/24 at 11:09 AM, the surveyor interviewed the U.S. FO who stated she was aware of the missing NJ Ex Order 26 for Resident #46. The U.S. FO stated the facility tried to find the NJ Ex O but they were unable to find it. She further stated she called the NJ Ex Order 26.4(b)(1) company and left voice messages, but no one was returned the call.

On 06/28/24 at 11:11 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated she was aware the NJ Ex Order 26 was missing. She stated the resident's family and the doctor were made aware at the time. The NJ Ex Order 26.4(b) stated that the insurance company had been called. The NJ Ex Order 26.4(b reviewed the eMAR in the presence of the surveyor who

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verified the active PO dated [redacted]: "[redacted] to [redacted] ON in AM and OFF in PM [redacted] and [redacted]. every day and night shift for [redacted]." She stated, "I would have my nurse put in a progress note if something was not done according to the order." The [redacted] showed the surveyor the [redacted] progress note regarding the [redacted] She was unable to find additional progress notes regarding the [redacted] at that time. The [redacted] verified that a check symbol for the [redacted] PO on the eMARs indicated that both [redacted] were signed as being administered and removed.

On 06/28/24 at 11:31 AM, the surveyor interviewed Resident #46s assigned [redacted] who stated the resident had [redacted] but one was lost and we tried to call the [redacted]. She stated the [redacted] had been missing for [redacted] months. She verified if a PO was signed it means it was completed as ordered. The [redacted] reviewed the eMAR in the presence of the surveyor. She acknowledged that she had signed that both [redacted] had been administered several times on the day shift. She stated, "I signed because it is one order." She further stated that she should have done a progress note because it (the order) was not done as it was ordered. The [redacted] was unable to find any progress notes that she had made regarding the [redacted] at that time. She acknowledged that the doctor should have been called to change the PO. The surveyor asked the [redacted] what's the purpose of accurate documentation was, she stated, "to put correct information for what is going on with the patient."

On 06/28/24 at 11:58 AM, the surveyor

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F 658	Continued From page 27 interviewed the facility's U.S. FOIA (b) (6) who stated she was aware of Resident #46's missing NJ Ex O She stated the U.S. FOIA (b) (6) was looking into it the day it happened but she was unaware that it was still missing. The U.S. FOIA reviewed the electronic medical records in the presence of the surveyor who verified active PO for both the NJ Ex Order 26.4(b)(1). She reviewed the eMARs for NJ Ex Order 26 NJ Ex Orde NJ Ex Or and NJ Ex Order She acknowledged that the NJ Ex Orde PO for both NJ Ex Or and NJ Ex Order 26 had been signed as administered and removed. She stated, "they (the nurses) signed for it. The check mark means it was done. It means they signed that they did it." She further stated, "when you sign something, you need to do it, if you don't it is not happening." The U.S. FOIA stated, 'your (nurses) not allowed to sign for something that never happened, this (signing an order was done) is a something you did not do but you (the nurses) still signed." She stated it was important to put the order on hold until you get what you need and to call the physician to get the correct order. She further stated that she and the U.S. FOIA (b) (6) should have been made aware that the NJ Ex had not been replaced. On 06/28/24 at 01:12 PM, during a meeting with the survey team, the U.S. FOIA (b) (6) , the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)), the surveyor presented the above concerns. The U.S. FOIA (b) stated, "this is not acceptable to check you are doing it and your not." The U.S. FOIA (b) (6) stated, "staff was expected to follow standards of practice for documentation." A review of the facility's policy titled, "Use of	F 658		

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Assistive Devices" revealed under "#3. The facility will provide assistive devices for residents who need them. Nursing, dietary, social services, and therapy departments will work together to ensure availability of devices, such as for ordering and/or replacement." and "#6. A nurse with responsibility for the resident will monitor of the consistent use of the device and safety in the use of the device. Refusals of use, or problems with the device, will be documented in the medical record. Modifications to the plan of care will be made as needed."

b-1.) On 6/25/24 at 10:00 AM, the surveyor observed Resident #101 who was [redacted] and [redacted] and was in bed watching television. The resident was [redacted] and had [redacted] with care.

The Surveyor reviewed the hybrid medical record (medical record is a combination of electronic and paper records) of Resident #101 which revealed the following:

According to the Admission Record (AR), Resident #101 had diagnoses that included but were not limited to [redacted], and [redacted].

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F 658	Continued From page 29 A review of the quarterly Minimum Data Set (qMDS) assessment, a tool used to facilitate management of care, dated [NJ Ex Order 26.4], indicated the facility assessed the resident's cognition using a BIMS test. Resident #101 scored a [NJ] out of 15, which indicated the resident was [NJ Ex Order 26.4(b)(1)] [redacted] A review of the [NJ Ex Order 26.4(b)(1)] physician's Order Summary Report (OSR) revealed no PO for a code status. A review of the resident's medical chart that was located on the [NJ Ex] floor nursing unit revealed no Practitioner Orders for Life-Sustaining Treatment (POLST) ([NJ Ex Order 26.4(b)(1)] [redacted] or any readily available documentation indication the resident's [NJ Ex Orde] [redacted]. On 6/26/24 at 10:40 AM, the surveyor in the presence of Licensed Practical Nurse (LPN#1), who was responsible of Resident #101, reviewed the resident's hybrid medical chart which included the resident's electronic and paper chart. LPN#1 could not locate any documentation that showed the resident's [NJ Ex Order 26.4(b)(1)]. LPN #1 stated that she will need to verify the resident's [NJ Ex Order 26.4(b)(1)]. LPN #1 further stated that if the resident's does not have any listed [NJ Ex Order 26.4(b)(1)], the resident will be considered a [NJ Ex Order 26.4(b)] [NJ Ex Order 26.4(b)(1)] [redacted]).	F 658		

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On 6/26/24 at 10:45 AM, the surveyor interviewed the [redacted] floor Registered Nurse (RN#1) who acknowledged that Resident #101 had no [redacted] RN #1 also stated that a [redacted] was only required if the resident had a [redacted]) and NJ Ex Order 26.4(b)(1)) [redacted]. All the other residents with no [redacted] in the medical chart were considered as NJ Ex Order 26.4(b)(1).

On 6/26/24 at 10:50 AM, the surveyor interviewed the 4th floo U.S. FOIA (b) (6) [redacted]) who acknowledged that there were no [redacted] indicated in Resident #101's medical chart.

On 06/28/24 at 1:10 PM, the surveyor discussed the above concerns with the administration team which included the [redacted] and the [redacted] There was no additional information provided.

A review of the facility's policy titled "Resident's Rights Regarding Treatment and Advanced Directives" that was undated and was provided by the [redacted] revealed the following: "3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff."

a-2.) On 06/25/24 at 10:35 AM, the surveyor observed Resident #45 in bed watching television. The resident was [redacted] and was NJ Ex Order 26.4(b)(1) and had [redacted] with care.

The surveyor reviewed the hybrid medical record of Resident #45 which revealed the following:

According to the AR, Resident #45 had diagnoses

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that included but were not limited to, [redacted] NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) [redacted]).

A review of the qMDS assessment, a tool used to facilitate management of care, dated [redacted], indicated the facility assessed the resident's cognition using a BIMS test. Resident #45 scored a [redacted] out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) .

A review of the [redacted] physician's OSR revealed a PO dated [redacted] for "[redacted] oral tablet [redacted] give 1 tablet via [redacted]) every 8 hours as needed for NJ Ex Order 26.4(b)(1) for 2 weeks."

A review of the [redacted] eMAR revealed a PO dated [redacted] for [redacted] oral tablet [redacted] give 1 tablet via [redacted] every 8 hours as needed for NJ Ex Order 26.4(b)(1) for 2 weeks". Further review of the eMAR revealed that a nurse signed indicating that the above medication was administered on [redacted] at 1935 (7:35 PM).

A review of the facility progress notes dated [redacted] at 15:57 (3:57 PM) revealed a Health Status Note which documented the following "received patient sitting at the nursing station ready for [redacted] appt (appointment) at [hospital redacted]; patient is [redacted] and [redacted] with NJ Ex Order 26.4(b)(1) [redacted].

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NJ Ex Order 26.4b1) status maintained as ordered and morning meds (medications) withheld. At 10:02 am, patient left facility via NJ Ex Order 26.4(b with transport and nursing staff in NJ Ex Order 2 condition. At 2:10 pm, patient returned to facility, NJ Ex Or and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) removed; NJ Ex O checked, NJ Ex Order 26.4(b intact, no NJ Ex Order 26.4(b)(1) noted with less than NJ Ex Order 26.4(b)(1) . NJ Ex Order 26.4(b)(1) noted post tray set up. Staff will continue to monitor patient for further care."

On 06/28/24 at 1:10 PM, the surveyor discussed the above concerns with the administration team which included the U.S. FOIA (b)(U.S. FOIA (b) U.S. FOIA and the U.S. FOIA

On 7/1/24 at 8:50 AM, the surveyor interviewed the NJ Ex floor U.S. FOIA (b)(6) who stated that Resident #45's NJ Ex Order 26 was removed on NJ Ex Order 26.4 . The U.S. FOIA (b) (6) further stated that the PO dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) had the incorrect route (NJ Ex O and the PO should have been verified by a nurse.

There was no additional information provided.

A review of the facility's policy titled, "Medication Administration" that was undated and was provided by the U.S. FOIA that revealed the following: "10. Review MAR to identify medication to be administered."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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b-2.) On 06/26/24 at 10:00 AM, the surveyor reviewed Resident #146's electronic medical records which revealed the following information:

The AR indicated that Resident #146 was admitted to the facility with the diagnoses which included but was not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)). The qMDS, an assessment tool that facilitates a resident's care, dated NJ Ex Order 26.4(b) indicated that the resident had NJ Ex Order 26 .

A review of the progress notes (PN) documented by the facility's U.S. FOIA (b) (6), dated NJ Ex Order 26.4(b)(1) at 13:05 (01:05 PM), indicated that Resident #146 had a NJ Ex Order 26.4(b)(1) .

The surveyor reviewed the nursing PN dated NJ Ex Order 26.4(b)(1) at 09:07, which revealed that Resident #124 had a NJ Ex Order 26.4(b)(1) and the staff performed NJ Ex Order The PN also indicated that NJ Ex Order 26.4(b)(1) number was called who then NJ Ex Order 26.4(b)(1) Resident #124 NJ Ex Order 26.4(b)(1)

The surveyor reviewed the physician OSR which did not include a PO for the resident's code status.

On 06/26/24 at 10:12 AM, the surveyor interviewed the facility's U.S. FOIA (b) (6)) who stated that Resident #146 was NJ Ex Order 26.4(b)(1)) and was considered an automatic NJ Ex Order 26.4(b) . The U.S. FOIA (further explained that Resident #146 had a NJ Ex Order 26.4b1 who was making the decisions on the resident's behalf. The U.S. FOIA (reviewed the residents medical

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record in the presence of the surveyor and stated that she could not find a PO or any documentation in the resident's profile that Resident #146 had [redacted]. The [redacted] stated that the only documentation for the resident's a [redacted] was included the social service progress notes.

On 06/27/24 at 09:20 AM, the surveyor interviewed the [redacted] on the third floor who explained the process regarding identifying a resident's code status. The [redacted] stated that if a resident [redacted] the nurse would immediately check the resident's profile section on the EMR to determine if the resident was a [redacted] or if the resident was a [redacted] The [redacted] stated that a PO would not be required for a "code" status. The [redacted] reviewed the resident's profile in the presence of the surveyor and confirmed that the [redacted] was not documented on the resident's profile in the EMR. The [redacted] further confirmed that there was no PO for a code status, however there was a documentation in the PN from the [redacted] that the resident was a [redacted] secondary to being a [redacted].

On 06/27/24 at 09:35 AM. the surveyor interviewed the [redacted] on the [redacted] floor who explained the process of obtaining a [redacted] for a resident. The [redacted] stated that when a resident was admitted to the facility, the nurse reviewed the Universal Transfer Form (UTF) and the POLST that was found from the hospital records which would usually indicate the residents [redacted]. The [redacted] stated that a

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PO was required for a resident's [NJ Ex Order 26.4(b)(1)] and must be documented on the resident's physical chart and on the resident's profile in EMR. The [U.S. FOIA (b) (6)] reviewed Resident #146's EMR with the surveyor and confirmed that there was no [NJ Ex Orde] PO for Resident #146 nor was the [NJ Ex Order] documented on the resident's profile of the EMR. The [U.S. FOIA (b) (6)] explained that when a resident was a [NJ Ex Order 26.4(b)(1)], the resident was automatically considered a [NJ Ex Order 26.4(b)]. The [U.S. FOIA (b) (6)] further stated that it would be important for the staff to obtain a PO for a resident's [NJ Ex Orde] and must be documented on the resident's profile because "time was of the essence" when determining if the resident required [NJ Ex Orde] or not in the event of [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b) (6)] added that staff would not have the time to read all the PN to determine a resident's [NJ Ex Order 26.4(b)(1)], but that if the [NJ Ex Order 26.4(b)(1)] was readily visible in the resident's profile or in the PO where it could be seen right away in [NJ Ex Order 26.4(b)(1)]

On 07/01/24 at 10:44 AM, the surveyor interviewed the [U.S. FOIA] who explained that a resident's [NJ Ex Order 26.4(b)(1)] should be documented in the resident's profile in the EMR. The [U.S. FOIA] also stated that a PO was required for a [NJ Ex Order 26.4(b)(1)]. There was no further information provided.

A review of the facility's policy titled, "Resident Rights Regarding Treatment and Advanced Directives" dated 09/2023 indicated that any decision regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.

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F 658	Continued From page 36 NJAC 8:39-11.2 (b); 29.2(d)	F 658		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure the primary physician (PP) addressed and evaluated the resident's NJ Ex Order 26.4(b)(1) [redacted] in a timely manner for 2 of 6 residents (Resident #131 and #95) reviewed for nutrition. The deficient practice was evidenced by the following: 1. On 6/25/24 at 10:52 AM, the surveyor	F 710	1. Corrective actions/measures (a) Resident #131 and #95 had NJ Ex [redacted] due to the alleged deficient practice. 6/24/2024 (b) Administrator/DON educated the U.S. FOIA (b) (6) on the facility Weight Monitoring policy and procedures for addressing and documenting any significant weight changes noted in the residents electronic medical records. 2. Residents with potential to be affected by the alleged deficient practice.	7/23/24

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F 710	Continued From page 37 observed Resident #131 in bed. When interviewed, Resident #131 was noted [redacted] and [redacted] Resident stated they had [redacted] over the past six months and was unable to recall the last time seeing PP#1. The surveyor reviewed the Admission Record (AR) (one page summary of important information about a resident) for Resident #131. The resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted], [redacted], [redacted], and [redacted]. A review of the Quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care), dated [redacted], reflected that Resident #131 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident was [redacted] the interview. The MDS further reflected Resident #131 had a [redacted] that was not a prescribed [redacted] regimen. On 6/27/24 at 9:55 AM, the surveyor reviewed Resident #131's electronic (EMR) and paper medical record (PMR). The surveyor reviewed the [redacted] record in the EMR, the [redacted] documented were as follows: [redacted] A review of the [redacted] progress notes (PN), dated [redacted] documented that Resident #131 had a [redacted] of [redacted] in 30 days. Further review	F 710	(a) All residents that reside in the facility can be affected by the deficient practice. 3. Systemic change/s to ensure alleged deficiency practice does not recur (a) 6/24/2024 DON/Designee provided education to the Interdisciplinary team ([redacted] Unit Managers, Nursing Supervisors, Medical Records, [redacted] and the [redacted] on the facility policy for Weight Monitoring addressing and documenting any significant weight changes addressed in the residents electronic records. 4. How to monitor corrective measures. (a) DON/Unit Manager/Designee will audit 5 medical charts weekly for four weeks and then every two weeks for two months and then monthly for three months for residents with significant weight changes. 5. The audit results will be presented at the monthly QAPI meeting for review and revision as appropriate. Adverse findings will be addressed immediately, and trends will be reported to Quality Assurance and Performance Improvement Committee at least quarterly.	

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revealed there were no monthly physician's PN. The surveyor interviewed the NJ Ex O Floor Unit Manager (UM#1) who confirmed she was not able to find any physician PN in the EMR and PMR but stated the PP#1 does come in frequently. The UM#1 called PP#1, who stated that all their notes were documented in the EMR. The UM #1 in the presence of the surveyor reviewed both EMR and PMR but could not locate any physician's PN.

On 6/28/24 at 10:51 AM and 12:45 PM, the surveyor attempted to contact PP #1 via phone call but was unavailable for interview.

2. On 6/25/24 at 11:37 AM, the surveyor observed Resident #95 at bedside. The surveyor was unable to interview the resident. The surveyor conducted a phone interview with Resident #95's family, who stated the resident had NJ Ex Order 26.4(b)(1) since being admitted to the facility, but not sure of exact amount. The family further stated, they have not spoken to Resident's PP #2.

The surveyor reviewed the AR for Resident #95. The resident was admitted to the facility on 6/3/2022 with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).

A review of the Q/MDS, dated NJ Ex Order 26.4, reflected that Resident #95 had a BIMS score of NJ Ex indicating NJ Ex Order 26.4(b)(1).

On 6/27/24 at 9:59 AM, the surveyor reviewed Resident #95's EMR and PMR chart. The surveyor reviewed the NJ Ex Order 26.4(b)(1) in the EMR,

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the weights documented were as follows:

NJ Ex Order 26.4(b)(1) : NJ Ex Order 26.4(b)(1 .
NJ Ex Order 26.4(b)(1) : NJ Ex Order 26.4(b)(1 .
NJ Ex Order 26.4(b)(1) : NJ Ex Order 26.4(b)(1 .
NJ Ex Order 26.4(b) : NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4(b)(1) : NJ Ex Order 26.4(b)(1)
NJ Ex Order 26.4(b)(1) : NJ Ex Order 26.4(b)(1 .

A review of the RD PN dated, NJ Ex Order 26.4(b)(1), documented that Resident #95 had a significant NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) in 180 days.

A review of the EMR revealed there with no monthly physician's PN in the EMR. The surveyor interviewed the UM#1, who stated the PP #2 wrote all their physician PN in the PMR. The surveyor reviewed the PMR which revealed that PP#2 documented their monthly PN, but all the PN were illegible (not clear enough to be read). The UM#1 was unable to read the physician PN and was unable to state if PP #2 addressed Resident #95's significant NJ Ex Order 26.4(b)(1), UM#1 stated PP#2 is usually available when called and will decipher (interpret) the PN when needed.

On 6/28/24 at 11:35 AM, the surveyor interviewed the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), all agreed the PP's need to address any significant NJ Ex Order 26.4(b)(1) in their monthly PN.

On 6/28/24 at 12:00 PM, the U.S. FOIA provided the surveyor with a facility policy titled, "Weight Monitoring" with a revised date 9/2023. Under the policy explanation and compliance guidelines it states, "3. B. The physician should be encouraged to document the diagnosis or clinical

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F 710	Continued From page 40 conditions that may be contributing to the weight loss." On 6/28/24 at 1:12 PM, the survey team met with the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)]. The [U.S. FOIA (b) (6)] stated the PP's need to address any significant [NJ Ex Order 26.4(b)(1)] in the monthly PN. No further information was provided. On 7/1/24 at 10:11 AM, the surveyors conducted a phone interview with PP#2, who could not state the Resident #95's significant [NJ Ex Order 26.4(b)(1)] was addressed in their monthly PN.	F 710		
F 712 SS=D	NJAC 8:39-23.2 (b) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in	F 712		7/23/24

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F 712	Continued From page 41 accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record reviews, it was determined that the facility failed to 1. ensure that the responsible physician supervising the care of residents conducted face-to-face visits and wrote progress notes at least once every 30 days and 2. ensure the physician reviewed and signed the monthly physician orders (PO). This deficient practice was identified for 3 of 32 residents (Resident #131, #7, and #77), reviewed for physician visits, and was evidenced by the following: 1. On 6/25/24 at 10:52 AM, the surveyor observed Resident #131 in bed. When interviewed, Resident #131 was noted to be NJ Ex Ord and NJ Ex Order 26.4(b)(1) The resident was unable to recall the last time seeing their Physician (MD). The surveyor reviewed the Admission Record (one-page summary of important information about a resident) (AR) for Resident #131. The resident was admitted to the facility on NJ Ex Order 26.4(b)(1) with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) A review of the Quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care), dated NJ Ex Order 2, reflected that Resident #131 had a Brief Interview for Mental Status (BIMS) score of NJ Ex O indicating the resident was NJ Ex Order 26.4(b)(1) the interview. On 6/27/24 at 9:55 AM, the surveyor reviewed Resident #131's electronic and paper chart. During the review, it was revealed that there were	F 712	1. Corrective action/measures (a) Resident # 131, # 7, #77 had NJ Ex [redacted] due to the deficit practice. (b) 6/4/2024 Primary Physicians were educated by the Director of Nursing and Administrator on the regulations and the facility policy and procedures for Physician Visits and Delegation. The physician should write, date, and sign progress notes and orders for each visit pertaining to the resident□s total program care. 2. Residents with potentials to be affected by alleged deficient practice (a) All residents that reside in the facility have the potential to be affected by the deficit practice. 3. Systemic changes/monitoring (a) Unit Mangers/Designee will audit 10 medical charts for physician visits with signed progress notes weekly for four weeks and then every two weeks for two months and then monthly for three months. 5. The audit results will be presented at the monthly QAPI meeting for review and revision as appropriate. Adverse findings will be addressed immediately, and trends will be reported to Quality Assurance and Performance Improvement Committee at least quarterly.	

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no monthly physician's PN. The surveyor interviewed the [NJ Ex Order 26.4b1] Unit Manager (UM#1), who confirmed she could not find any physician PN in either chart but stated the MD does come in frequently. The UM#1 called the MD, who stated all their notes were documented in the electronic chart. The surveyor and UM#1 reviewed both the electronic and paper charts but could not locate any MD PN.

On 6/28/24 at 10:51 AM and 12:45 PM, the surveyor attempted to contact the MD for Resident #131 via phone call but was unavailable for interview.

On 6/28/24 at 11:35 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the [U.S. FO] was required to have monthly PN in the electronic or paper chart but was unable to explain why the [U.S. FO] had not written their monthly physician PN.

On 6/28/24 at 1:12 PM, the survey team met with the U.S. FOIA (b) (6) [U.S. FOIA (b)] U.S. FOIA (b) (6)), and U.S. FOIA (b) (6)). The [U.S. FOIA] and [U.S. FOIA] both stated that the MDs are expected to write a progress note monthly and after each visit.

On 7/2/24 at 10:13 AM, the survey team met with the [U.S. FOIA (b) (6)] [U.S. FOIA (b)] [U.S. FOIA (b)] and [U.S. FO] for an exit meeting. Facility staff made no further comments.

2. On 06/25/24, at 10:45 AM, the surveyor

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F 712	Continued From page 43 observed Resident #7 in bed [redacted] and [redacted] able to answer the surveyor's inquiry. A review of Resident #7's hybrid (paper and electronic) medical record revealed the following information: According to the AR, Resident #7 was admitted to the facility with diagnoses that included but were not limited to [redacted]). The Annual MDS, dated [redacted], indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored [redacted] out of 15, which indicates an [redacted]. A review of the hybrid medical record for Resident #7 revealed that the resident's physician had not hand-signed or electronically signed the monthly PO for [redacted]. Furthermore, there were no physician PN in [redacted]. On 7/01/24 at 10:31 AM, the surveyor interviewed the physician for Resident #7 over the phone to inform that the monthly PO from [redacted] were not reviewed and signed. Additionally, there were no physician PN for [redacted]. The [redacted] stated he was in the facility but the staff did not tell him to sign the monthly PO. The [redacted] added that if he needed to sign something immediately, he can come to the facility to sign them. 3. On 6/25/24 at 10:27 AM, the surveyor observed Resident #77 sitting in bed, [redacted] with	F 712		

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eyes open and NJ Ex Order 26.4b1 answer the surveyor's inquiry.

The surveyor reviewed the hybrid medical record of Resident #77, which revealed the following:

The resident's AR documented that Resident #77 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)).

The QMDS, dated NJ Ex Order 26.4(, indicated that the facility assessed the residents' cognitive status using a BIMS score of NJ E out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1) .

A review of the hybrid medical record for Resident #77 revealed the resident's physician had not hand-signed nor electronically signed the monthly PO for NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) .

On 7/01/24 at 09:46 AM, the U.S. FOIA (b) (6) stated that the U.S. FC was at the facility but didn't know why the U.S. FC missed to review and sign the PO. The U.S. FOIA (b) (6) from the 3rd floor stated she was unaware that the U.S. FC must sign the monthly PO.

On 7/01/24 at 10:35 AM, the surveyor interviewed the U.S. FC over the phone regarding the above concern. The U.S. FC stated that he usually signed his monthly PO on the paper medical chart. The U.S. FC was informed that the monthly PO from U.S. FOIA (b) (6) through U.S. FOIA (b) (6) were not signed and the U.S. FC could not provide further information.

On 7/01/24 at 10:41 AM, the surveyor team met

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F 712	Continued From page 45 with the [redacted] and [redacted] to discuss the above concern. The [redacted] stated that the [redacted] was in charge of having the [redacted] review and sign the monthly PO's. If the [redacted] were not in the building, the [redacted] would call the [redacted] to sign the monthly PO. A review of the the facility's policy dated 9/2023 provided by the [redacted] titled "Physician Visits and Delegation" under "Policy Explanation and Compliance Guidelines" revealed that: "b. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by a physician or physician delegate as appropriate by State law; c. Review the resident's total program of care, including medications and treatments, at each visit; d. Date, write, and sign a progress note for each visit., e. Sign and date all orders except for the flu and pneumococcal vaccines, which may be administered per physician-approved policy after an assessment for contraindications." NJAC 8:39-23.2 (b), 23.2 (d)	F 712		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806		7/23/24

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F 806	Continued From page 46 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Complaint# NJ00166657 Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure a resident's food preference were honored. This deficient practice was identified for 1 of 1 resident reviewed for food preferences (Resident #4), and was evidenced by the following: On 06/26/24 at 12:26 PM, the surveyor observed Resident #4's lunch tray. The meal ticket indicated 16 ounces of skim milk and the lunch tray contained 8 ounces of whole milk. On 06/27/24 at 12:12 PM, the surveyor observed Resident #4's lunch tray. The lunch ticket indicated 16 ounces of skim milk and lunch tray contained 8 ounces of whole milk. The surveyor interviewed Certified Nursing Assistant (CNA) #1 and U.S. FOIA (b) (6)) who stated that they check the contents of the trays against the meal tickets. The U.S. FOIA (b) (6) stated that Resident #4's lunch tray was correct. On second check, the U.S. FO NJ Ex C stated that the milk was incorrect and that should've caught it at the cart before it was brought into the room. A review of the electronic medical record (EMR) indicated that Resident #4 was admitted with diagnosis including but not limited to NJ Ex Order 26 (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) .)	F 806	1. Corrective measures/actions. (a) The US FOIA (b)(6) was educated by the Regional director of dietary services on the facility policy - "Policy: All trays will be properly et up according to the designated tray card ticket, reflecting the individual resident's dietary needs and preferences on 6/28/24 2. Residents with potentials to be affected bvy the alleged deficient practice. (a) All residents could potentially be affected by alleged deficient practice. 3. Systemic change/s to ensure deficient practice does not recur. (a) Food services director will maintain a binder to record all tray audits. (b) All dietary staff were educated on making sure that the right meal choices are served to residents by making sure that what is on meal card is what is being served. 4. How to monitor measures (a) The food services director will audit trays three times a day continiously to ensure that residents are served proper diets and texture. 5. Result of audit to be submitted to quarterly QAPI for review, revision and recommendations.	

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F 806	Continued From page 47	F 806		

A review of the order summary included a physician order for a [NJ Ex Order 26.4(b)(1)] NJ Ex Order 26.4(b)(1)) diet [NJ Ex Order 26] texture, [NJ Ex O] consistency, [NJ Ex Orde] portions.

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, revealed a Brief Interview for Mental Status (BIMS) score of [NJ Ex] indicating [NJ Ex Order 26.4(b)(1)]

A review of Resident #4's care plan titled, "Nutrition" indicated an intervention of "Provide me with my food/beverage preferences as available."

A review of facility's policy titled, "Tray Accuracy" indicated:
"Policy: All trays will be properly et up according to the designated tray card ticket, reflecting the individual resident's dietary needs and preferences.
Procedure:
Each resident's individual meal tray will be set up and made according to the resident's personal meal tray card ticket. All items described on this ticket will be present on the tray. The defined diet and the individual needs and food preferences will be present on the tray. The defined diet and the individual needs and food preferences will be present on the tray including likes and dislikes in accordance with the compliance guidelines.
All trays will be checked by the dietary representative calling the tray line and setting up each tray. Each tray will then be checked by a Dietary management team member prior to being sent to the unit.
On received on the unit, the healthcare professional will check the tray prior to serving it

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F 806	Continued From page 48 to the resident." On 06/28/24 01:26 PM, the surveyor met with the facility's U.S. FOIA (b) (6), U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6) to discuss the above concerns. There was no further information provided. NJAC 8:39-17.4(a)1, 27.1(a)	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary 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 review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices as well as store potentially hazardous	F 812	1. Corrective Measures/Actions (a) Maintenance department installed additional A/C in the dry food storage area and temperature was restored to 65	7/23/24

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F 812	Continued From page 49 foods in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 6/25/24 at 9:35 AM, the surveyor in the presence of U.S. FOIA (b) (6)) observed the following during the kitchen tour: 1. The dry storage area was noted with a temperature of 80 degrees Fahrenheit (F), the temperature was observed on two different thermometers. U.S. FOIA stated recent heatwave caused dry storage room to become warmer, and maintenance was aware. 2. In the Walk in freezer, the surveyor observed boxed items being stored on the floor and stacked to ceiling. U.S. FOIA acknowledged they were not following the 6 inches (in) from the ground and 18 in from the ceiling guidelines. 3. In the cooking area of the kitchen, the surveyor observed dual ovens, both ovens noted with a black colored baked-on debris. 4. In the Chef preparatory area, the surveyor observed on the spice storage rack multiple open seasonings without open or use by dates. The following spices were open: 6 ounce (oz) kosher salt, 6oz cinnamon, 6oz granulated garlic, and 24oz adobe seasoning. The U.S. FOIA could not state when they had been opened. 5. In the bread storage area, the surveyor observed multiple open bags of sliced white bread (4), hamburger buns (3) and hotdogs buns (2) without open/use by labels. U.S. FOIA could not state when they had been opened.	F 812	degrees on 6/25/24 (b1) The freezer compartment was re-arranged to maintain 6 inches off the floor and 18 inches from the ceiling by kitchen staff on 6/24/24 (b2) Regional director for dietary services purchased a chest freezer to alleviate congested freezer issues on 7/11/24 (c) All ovens were immediately cleaned by kitchen staff on 6/24/24. (d) Opened items on the rack that were not dated were immediately discarded and replaced with dated items on 6/24/24 2. Residents with potentials to be affected by alleged deficient practice. (a) All residents can potentially be affected by alleged deficient practice. 3. Systemic changes/measures to ensure deficient practice does not recur. (a) US FOIA (b)(6) were in serviced by the Regional Director of Food Services to make sure the dry storage area was at the right temperature of 50 to 70 degrees. (b) Food services director in-serviced all dietary staff on maintaining required 6 inches from the ground and 18 inches from the ceiling while storing food in the freezer. (c) Food services director in-serviced dietary staff on cleaning ovens after every use. (d) Food service director in-serviced all dietary staff on dating and labelling all items and to make sure all bread are always properly sealed and placed.	

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F 812	Continued From page 50 On 7/1/24 at 10:40 AM, the survey team met with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), U.S. FOIA (b) (6)), and U.S. FOIA (b) (6)). The surveyor reviewed the kitchen inspections concerns. On 7/1/24 at 11:00 AM, the U.S. FOIA (b) provided the surveyor with multiple facility polices including Food Storage and Dating and Labeling Policy both with revised dates of 2/24/24. The Food Storage policy states under the procedure section, "1. All items with be stored on shelves at least 6 inches above the floor. 3. Items will be stored at least 18 inches of a sprinkler unit. 8. The temperature of the dry storage room for food items will maintain a temperature of 50-70 degrees Fahrenheit at all times." The Dating and Labeling Policy states under the procedure section, "2. Label products in storage with the date the package was opened or the expiration date with no more than 48 hours after opening, whichever is appropriate. 3. Label all dry goods with date received. 7. Foods that are marked with manufactures use by date, once opened and or used, must be marked with the open or use by date and that date must be used. All food items need to be dated with open date once opened." On 7/2/24 at 10:13 AM, the survey team met with the U.S. FOIA (b) (U.S. FOIA (b) U.S. FOIA (b) and U.S. FOIA There was no additional information provided. NJAC 8:39-17.2(g)	F 812	4. How to monitor measures (a) Food services director to monitor dry storage area daily to ensure temperature is within 50 to 70 degrees and to report to maintenance and administrator immediately if temperature is off range. (b) Food services director inspect freezer daily for 12 weeks to ensure that required 6 inches from the ground and 18 inches from the ceiling is maintained. (c) Food services director to monitor and ensure that ovens are cleaned after every use daily for 12 weeks. (d) Food services director/designee to check all rack items for dating weekly for 12 weeks. (e) Regional director of dietary services to conduct monthly audits of 'a' through 'd' for 3 months. 5. results of audits/monitoring will be submitted to quarterly QAPI for review, revision and recommendations.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		7/23/24

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§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

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F 842	Continued From page 52 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain complete, accurate, readily accessible medical records, and legible physician's progress notes (PN). This deficient practice was identified for 3 of 29 residents reviewed, Resident#121, #95 and #77, and was evidenced by the following: This deficient practice was evidenced by the following:	F 842	1. Corrective action/measures (a) Residents #121, #95, and #77 had NJ E [redacted] due to the deficit practice. (b) 6/28/2024 The Hospice Services were educated on the facility policy and procedures on Coordination of Hospice services to include the facility will maintain communication with supporting documents with hospice as it relates to the residents plan of care and services	

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1. On 6/25/24 at 10:30 AM, during initial tour, the surveyor observed the Resident #121 in bed with their eyes closed.

A review of the Admission Record (an admission summary) (AR) for Resident #121 reflected that the resident was admitted to the facility with diagnoses which included but not limited to [redacted].

A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident's cognitive skills for [redacted] score were a [redacted] which indicated that Resident #121's cognition was [redacted]. The Q/MDS further indicated that the resident was [redacted]

A review of the [redacted] Order Summary Report revealed a physician's order dated [redacted] for "[redacted] to evaluate and treat."

A review of Resident #121's [redacted] care binder [redacted])which contained all the [redacted] care documentation for the resident, that was provided by the [redacted] floor [redacted]), revealed a form titled, "[redacted] Visit Description Log [redacted]" and

to ensure each entity is aware of their responsibility.
(c) 6/28/2024 The Administrator/DON in-service the [redacted] on the facility Physician visit and Delegation policy and procedure to maintain legible documentation and communication as it relates to the residents plan of care and services.

2. Residents with potentials to be affected by the alleged defficient practice.
(a) All residents that reside in the facility have the potential to be affected by the deficit practice.

3. Systemic changes/measures to ensure deficient practice does not recur
(a) DON/Designee provide on-going in-service to license nursing staff, social workers, activities, therapy and dietician on the facility policy and procedures with Hispice

4. How to monitor corrective measures
(a) DON/Designee will audit 10 charts weekly for four weeks and then every two weeks for two months and then monthly for three months.

5. The audit results will be presented at the monthly QAPI meeting for review and revision as appropriate. Adverse findings will be addressed immediately, and trends will be reported to Quality Assurance and Performance Improvement Committee at least quarterly.

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indicated it was last signed on [NJ Ex Order 26.4]. The [NJ Ex Ord] also included an interdisciplinary care plan and admission orders with initial plan of care. Further review of the [NJ Ex Ord] revealed no [NJ Ex Order 26.4] nursing PN for [NJ Ex Order 26.4(b)(1)]. The last [NJ Ex Order 26.4] nursing PN that was found was dated [NJ Ex Order 26.4(b)]. There were no further nursing PN found in the hybrid medical record or in the [NJ Ex Ord] for Resident #121.

On 6/28/24 at 9:30 AM, the surveyor interviewed the [NJ Ex] floor U.S. FOIA (b) (6)) who stated that Resident #121 was under [NJ Ex Order 26.4] care and a hospice aide would visit the resident daily. The [U.S. FOIA (b) (6)] further stated that the [NJ Ex Order 26.4] nurse would visit the resident weekly and any notes from the visit must be placed in the [NJ Ex Order]

On 6/28/24 at 11:30 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who explained the operation and the process of care of the [redacted] company. The [U.S. FOIA (b) (6)] stated that the aide visits will depend on the resident's care plan and whoever would visit the resident from the [redacted] company would need to fill out the [NJ Ex Order] form that must be dated with description of care. The [U.S. FOIA (b) (6)] further stated that a [NJ Ex Order 26.4] nurse would visit the resident weekly and every visit they need to leave a care note that must be dated with a description of the visit.

The surveyor informed the [U.S. FOIA (b) (6)] that the last [NJ Ex Order 26.4] nursing PN found in the resident's medical record was a supplemental interdisciplinary note dated on [NJ Ex Order 26.4] and the last entry in the form [NJ Ex Order] was on [NJ Ex Order 26.4], the [U.S. FOIA (b) (6)] stated that the copy of the nursing PN were at the [NJ Ex Order 26.4] company and there was no

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	315204	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE 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
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copy left at [redacted] for Resident #121.

On 6/28/24 at 1:00 PM, the surveyor presented the above concerns to the facility administrative staff which included the [redacted], the [redacted], [redacted], and [redacted].

No additional information provided.

A review of the facility's "Coordination of Hospice Services" policy that was undated and provided by the [redacted] revealed the following: "7. The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities."

2. On 6/25/24 at 11:37, surveyor observed Resident #95 in bed. The surveyor [redacted] interview the resident. The surveyor spoke with resident's family via phone. The resident's family stated they have not spoken to the [redacted] about Resident #95's care.

The surveyor reviewed the AR for Resident #95. The resident was admitted to the facility on [redacted] with diagnoses that included but were not limited to [redacted], [redacted], [redacted], and [redacted].

A review of the Q/MDS, dated [redacted], reflected that Resident #95 had a Brief Interview for Mental

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F 842	Continued From page 56 Status (BIMS) score of [NJ Ex] indicating [NJ Ex Order 28] [redacted] On 6/27/24 at 9:59 AM, the surveyor reviewed Resident #95's electronic and paper chart which revealed there with no monthly physician's PN in the electronic chart. The surveyor interviewed the [redacted] Manager (UM#1), who stated the MD wrote all their physician PN in the paper chart. The surveyor reviewed the paper chart which revealed the [U.S. FO] monthly PN were handwritten with all the writing noted to be illegible (not clear enough to be read). The UM#1 was unable to read the physician PN, but stated to the surveyor that the [U.S. FO] was usually available to be called and would interpret the notes when needed. On 6/28/24 at 11:35 AM, the surveyor discussed the above concern to the [U.S. FOIA (b)] [U.S. FO] and [U.S. FOIA (b)] All agreed on the importance for staff to be able to read the physician's PN. The [U.S. FOIA (b)] [U.S. FO] and [U.S. FOIA (b)] were not able to read the physician's PN for Resident #95. On 6/28/24 at 1:12 PM, the survey team met with the [U.S. FOIA (b)] [U.S. FOIA (b)] [U.S. FO] and U.S. FOIA (b) (6) [redacted]. The [U.S. FOIA (b)] stated the physician's PN if handwritten needed to legible to the facility staff. No further information was provided. On 7/1/24 at 10:11 AM, the surveyors conducted a phone interview with MD, who confirmed all their notes were handwritten and who stated they are always available if the facility staff needed to clarify their notes.	F 842		

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F 842	Continued From page 57	F 842		

3. On 6/25/24 at 10:27 AM, the surveyor observed Resident #77 sitting in bed, [redacted] and awake, [redacted] the surveyor's inquiry.

The surveyor reviewed the hybrid (paper and electronic) medical record of Resident #77, which revealed the following:

The resident's AR documented that Resident #77 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted]

The Q/MDS, dated [redacted] indicated that the facility assessed the residents' cognitive status using a BIMS score of [redacted] out of 15, which indicated that the resident had an NJ Ex Order 26.4(b)(1)

A review of the paper copy of the handwritten physician PN from NJ Ex Order 26.4(b)(1) through [redacted] showed that they were all illegible.

On 6/28/24, at 11:35 AM, the surveyors met with the [redacted] and [redacted] who both could not read all the monthly physician's PN.

On 7/01/24 at 10:35 AM, the surveyor interviewed the [redacted] over the phone. The [redacted] confirmed that he wrote all his PN on the paper and he can be reached anytime if the nurses cannot read or understand his handwriting.

On 7/1/24 at 10:47 AM, the survey team met with the [redacted] and discussed the above concerns. There was no further information provided.

A review of the facility policy titled "Physician Visits and Delegation" with the revised date of

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F 842	Continued From page 58 9/2023 did not specify about the physician's illegible handwriting. NJAC 8:39-35.2 (d)(5)	F 842		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ164805, NJ165096, NJ166184, NJ166657 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	S560 1. Corrective action/s (a) Staffing was reviewed by the Director of Nursing and Administrator; no residents were affected negatively by the deficient practice. (b) The facility cannot retroactively respond to the staffing ratio prior to the complaint survey. 2. Residents with potentials to be affected by alleged deficient practice. (a) All residents have potential to be affected by the deficient practice. 3. Systemic change/s to ensure alleged deficient practice doe not recur.	7/23/24

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

Electronically Signed | 07/25/24

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than	S 560	(a) The Director of Human Resources (HR) initiated an expedited on-boarding process for all new hires. (b) Interviews will be conducted on the spot with job offer (contingent of criminal background check). (c) Job openings are posted on all recruitment cites and facility bulletins. (d) Meeting with DON/designee will review staffing with staffing coordinator and collectively work to fill out any open shifts and callouts. (e) Bonuses are offered to staff as needed. (f) HR manager will contact and work with nursing and CNA schools within the area to recruit staff. (g) Building has partnered with Nursing school - NJ Ex Order 26.4b1 - and provided building for clinical rotation to foster recruitment of graduates. (h) Director of Nursing will continue to contact more nursing schools to partner to be a training facility for nursing school and CNA and offer positions once students graduate. (i) facility is paying upfront for staff to go to nursing school. 4. How to monitor corrective actions (a) The DON/Designee will monitor staffing ratios daily and document a review of staffing weekly for 2 months. 5. Audits will be presented to the Administrator weekly. Audits will be discussed at the monthly QAPI meetings to determine if continued auditing is needed. Once compliance is achieved for 2	

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S 560	Continued From page 2 a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for 5 segment dates that related to the standard survey and complaints revealing the following: 1. For the week of Complaint staffing from 06/04/2023 to 06/10/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on 1 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -06/04/23 had 7 CNAs for 142 residents on the day shift, required at least 18 CNAs. -06/05/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs. -06/06/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs. -06/07/23 had 8 CNAs for 139 residents on the	S 560	consecutive months, the plan will be amended as needed.	

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day shift, required at least 17 CNAs.
-06/07/23 had 9 total staff for 139 residents on the overnight shift, required at least 10 total staff.
-06/08/23 had 10 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/09/23 had 10 CNAs for 143 residents on the day shift, required at least 18 CNAs.
-06/09/23 had 11 total staff for 143 residents on the evening shift, required at least 14 total staff.
-06/09/23 had 9 total staff for 143 residents on the overnight shift, required at least 10 total staff.
-06/10/23 had 6 CNAs for 143 residents on the day shift, required at least 18 CNAs.

2. For the week of Complaint staffing from 06/18/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on 2 of 7 evening shifts, and deficient in total staff for residents on 3 of 7 overnight shifts as follows:

-06/18/23 had 7 CNAs for 141 residents on the day shift, required at least 18 CNAs.
-06/18/23 had 11 total staff for 141 residents on the evening shift, required at least 14 total staff.
-06/18/23 had 8 total staff for 141 residents on the overnight shift, required at least 10 total staff.
-06/19/23 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs.
-06/20/23 had 8 CNAs for 141 residents on the day shift, required at least 18 CNAs.
-06/21/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/22/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/23/23 had 9 CNAs for 139 residents on the day shift, required at least 17 CNAs.
-06/23/23 had 9 total staff for 139 residents on the overnight shift, required at least 10 total staff.
-06/24/23 had 6 CNAs for 139 residents on the

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day shift, required at least 17 CNAs.
-06/24/23 had 12 total staff for 139 residents on the evening shift, required at least 14 total staff.
-06/24/23 had 8 total staff for 139 residents on the overnight shift, required at least 10 total staff.

3. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shift, deficient in total staff for residents on 2 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows:

-07/30/23 had 8 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-07/30/23 had 9 total staff for 142 residents on the overnight shift, required at least 10 total staff.
-07/31/23 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-07/31/23 had 9 total staff for 142 residents on the overnight shift, required at least 10 total staff.
-08/01/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/02/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/02/23 had 12 total staff for 142 residents on the evening shift, required at least 14 total staff.
-08/03/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/04/23 had 11 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/05/23 had 7 CNAs for 142 residents on the day shift, required at least 18 CNAs.
-08/05/23 had 12 total staff for 142 residents on the evening shift, required at least 14 total staff.

4. For the week of Complaint staffing from 08/20/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts, deficient in total staff for residents on

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S 560	Continued From page 5 1 of 7 evening shifts, deficient in CNAs to total staff on 1 of 7 evening shifts, and deficient in total staff for residents on 2 of 7 overnight shifts as follows: -08/20/23 had 7 CNAs for 147 residents on the day shift, required at least 18 CNAs. -08/20/23 had 10 total staff for 147 residents on the evening shift, required at least 15 total staff. -08/20/23 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. -08/20/23 had 8 total staff for 147 residents on the overnight shift, required at least 10 total staff. -08/21/23 had 10 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/22/23 had 10 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/23/23 had 10 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/24/23 had 10 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/25/23 had 12 CNAs for 145 residents on the day shift, required at least 18 CNAs. -08/26/23 had 10 CNAs for 144 residents on the day shift, required at least 18 CNAs. -08/26/23 had 9 total staff for 144 residents on the overnight shift, required at least 10 total staff. 5. For the 2 weeks of staffing prior to survey from 06/09/2024 to 06/22/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 5 of 14 evening shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -06/09/24 had 6 CNAs for 150 residents on the day shift, required at least 19 CNAs. -06/09/24 had 9 total staff for 150 residents on	S 560		

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S 560	Continued From page 6 the evening shift, required at least 15 total staff. -06/09/24 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -06/09/24 had 9 CNAs for 150 residents on the overnight shift, required at least 11 total staff. -06/10/24 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/11/24 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/12/24 had 13 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/13/24 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/14/24 had 13 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/15/24 had 9 CNAs for 150 residents on the day shift, required at least 19 CNAs. -06/15/24 had 13 total staff for 150 residents on the evening shift, required at least 15 total staff. -06/15/24 had 9 total staff for 150 residents on the overnight shift, required at least 11 total staff. -06/16/24 had 7 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/17/24 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/17/24 had 13 total staff for 149 residents on the evening shift, required at least 15 total staff. -06/18/24 had 10 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/19/24 had 12 CNAs for 149 residents on the day shift, required at least 19 CNAs. -06/19/24 had 14 CNAs for 149 residents on the evening shift, required at least 15 total staff. -06/20/24 had 12 CNAs for 150 residents on the day shift, required at least 19 CNAs. -06/21/24 had 15 CNAs for 150 residents on the day shift, required at least 19 CNAs. -06/22/24 had 8 CNAs for 148 residents on the day shift, required at least 18 CNAs.	S 560		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7 -06/22/24 had 13 total staff for 148 residents on the evening shift, required at least 15 total staff. On 07/01/24 10:40 AM, the surveyor discussed the staffing ratio concerns with the facility's Licensed Nursing Home Administrator, Director of Nursing, Regional Clinical Registered Nurse and Regional Infection Preventionist. No further information was provided.	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
315204 Y1	A. Building B. Wing Y2	8/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0577	Correction	ID Prefix F0609	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed
LSC	07/23/2024	LSC	07/23/2024	LSC	07/23/2024
ID Prefix F0641	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	07/23/2024	LSC	07/23/2024	LSC	07/23/2024
ID Prefix F0710	Correction	ID Prefix F0712	Correction	ID Prefix F0806	Correction
Reg. # 483.30(a)(1)(2)	Completed	Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.60(d)(4)(5)	Completed
LSC	07/23/2024	LSC	07/23/2024	LSC	07/23/2024
ID Prefix F0812	Correction	ID Prefix F0842	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. #	Completed
LSC	07/23/2024	LSC	07/23/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
7/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060729 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 8/29/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE 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 07/23/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	
7/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING **01** B. WING _____	**07/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/02/2024 to 07/03/2024 and Canterbury at Cedar Grove was found to be non-compliance with the requirements for participation in Medicare and 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, Canterbury at Cedar Grove is a 4-story Type II protected building, built in 1984. The facility is divided into 12 smoke zones. The generator does approximately 50% of the building as per the Maintenance Director. The current occupied beds are 147 of 180.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/03/2024 in the presence of the facility U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined that the facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA	K 211	1. Corrective action/measure (a) The maintenance team cleaned and oiled the hinges and adjust the automatic door closer for the exit Door leading to the discharge in Stairwell #2 on 7/4/24 2. Residents with potentials to be affected	7/23/24

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

Electronically Signed | 07/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING **01** B. WING _____	**07/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 211	Continued From page 1 101:2012 Edition, Section 7.1.10.1. for 1 of 9 exits. This deficient practice had the potential to affect all 147 residents and was evidenced by the following: An observation at 9:00 AM of the exit door leading to the exit discharge in stairway #2 on the ground floor revealed the door would not readily open. Several attempts were made before the door could be opened. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 3:50 PM. N.J.A.C 8:39-31.2(e)	K 211	by alleged deficient practice (a) All residents had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur (a) The maintenance Director will create a weekly audit of all emergency exit doors for the next 2 quarter and move to a quarterly inspection there after 4. How to monitor corrective action (a) Maintenance director to inspect all exit doors, once weekly for 8 weeks, bi-weekly for 12 weeks, monthly for 3 months and quarterly thereafter. 5. Inspection/audit result to be submitted to quarterly QAPI committe meeting for review or revision.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/03/2024,in presence of the facility U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined	K 293	1. Corrective action (a) The maintenance director changed the non-illuminated light in the kitchen on	7/23/24

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	315204	A. BUILDING **01** B. WING _____	**07/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 293	Continued From page 2 that the facility failed to inspect and maintain exit signs to ensure exit and directional exit signs were provided and marked by approved, readily visible signs in all case where the exit or way to reach the exit is not readily apparent to the occupants in accordance with NFPA 101,2012 Edition, Section 19.2.10.1 and 7.10. These deficient practices had the potential to affect all 147 residents and was evidenced by the following: 1. An observation at 8:30 AM revealed the exit door between the elevator hallway and laundry hallway was not equipped with an illuminated exit sign on both sides. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation. 2. During the tour at 8:47 AM in the presence of the U.S. FO and U.S. FOIA (b) (6) the surveyor observed 1 of 3 exit signs in the kitchen door to main hallway were not illuminated. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 3:50 PM. N.J.A.C- 8:39-31.2(e)	K 293	7/05/24 (b) The missing hallway exit sign by double doors was installed 7/05/24 2. Residents with potentials to be affected by the alleged deficient practice (a) All residents could potentially be affected. 3. Systemic change to ensure alleged deficient practice does not recur (a) the US FOIA (b)(6) was re-educated by Regional maintenance director on the need to ensure that all light s are illuminated at all timesm on 7/05/24 (b) The maintenance director was educated to ensure that there is always an illuminated sign showing all exits out of the building on 7/5/24 4. How to monitor (a)The maintenance director will create a monthly audit for all exit signs to be checked monthly 5. Results of audit to be submitted to quarterly QAPI committee for review and revision	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour	K 321		7/23/24

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	315204	A. BUILDING **01** B. WING _____	**07/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 3 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/03/2024, in presence of the facility U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure the fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partition in accordance with NFPA 101: 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.6.3.4, 8.3,8.3.5.1, 8.4,8.5.6.2 and 8.7. This deficient practice was identified in 1 of 9	K 321	1. Corrective action (a) The maintenance director removed all the paint covered fire rating labels on the existing doors on 7/6/24 (b) Door closure was installed on 3rd floor storage room and case manager office door leading to reception area. 2. Residents with potentials to be affected by the alleged deficient practice	

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K 321	Continued From page 4 hazardous storage areas observed, had the potential to affect staff and all 147 residents, and was evidenced by the following: At 12:30 PM, surveyor, U.S. FOIA (b) and U.S. FO observed the room on the third floor next to nourishment room was being used for hazardous storage. The room was greater than 50 square feet in size and required auto-closing device installed on the door. The room was observed to have plastic medical equipment, a high-backed chair with cushions along with various combustible items. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observation. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 3:50 PM. N.J.A.C 8:39-31.2(e)	K 321	(a) All residents / staff had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur (a) Maintenance director was educate by Regional maintenance director on the need to ensure that all fire rating labels are legible on 7/6/24. (b) US FOIA (b)(6) was educate by Regional maintenance director on the need to ensure that all doors outside of fire doors are equiped with door closures. 4. How to monitor corrective action (a) The maintenance director will create a quarterly audit of all doors throughout the facility 5. result of audit to be submitted to quarterly QAPI committe meeting for review and revision	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and record review on 07/03/2024 in the presence of the facility	K 345	1. Corrective action.	7/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 345	Continued From page 5 U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , it was determined that the facility failed to ensure the operational integrity and maintain the fire alarm system in accordance with the requirements of NFPA 70, National Electrical Code, NFPA 72, National Fire Alarm and Signaling Code, and NFPA 101:2012 Edition, Section 9.6.1.3,9.6.1.5. This deficient practice had the potential to affect all 147 residents and was evidenced by the following: A review of documentation provided by U.S. FO at 8:00 AM, revealed the fire alarm "Inspection and Report" dated May 8, 2024 indicated the following devices failed inspection and no documentation was available indicating any repairs had been made. Initiating- waterflow Switch #85254384 Supervisory - Tamper Switch #8525485 Supervisory - Tamper Switch #8525486 Supervisory - Tamper Switch #852544 In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the finding. The U.S. FOIA (b) (6) was informed of the deficient practice at 3:50 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	(a)The company that services the alarm system was called on July 19 2024 and they will be out on date to make the repairs. 2. Residents with potential to be affected by the alleged deficient practice (a) All residents / staff had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur (a) The RDPO reeducated the U.S. FOIA (b) (6) on how to review all inspection report and ensure all repairs are done on a timely basis documentation kept with report on 7/5/24 4. How to monitor corrective action (a) The maintenance director will monitor and inspect all Tamper switched daily for 4 weeks, weekly for 4 weeks, bi-weekly for 4 weeks and monthly thereafter. 5. Result to be submitted to quarterly QAPI committee meeting for review and revision.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces	K 347		7/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 347	Continued From page 6 open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 07/03/2024 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery-operated smoke detectors. This deficient practice had the potential to affect all residents and was evidenced by the following: A tour of the facility at 11:30 AM, revealed that the resident rooms were provided with battery operated smoke detectors. A review of the maintenance logs provide by the U.S. FO did not indicate that there was a preventative maintenance program for the testing of the detectors or battery replacement. In an interview at 11:45 AM, the U.S. FO stated that there was no preventative maintenance program for testing the battery-operated smoke detectors in residents' rooms and could not provide any documentation on the year of installation. This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke condition prior to the smoke entering the exit corridor where permanently wired detectors were located. The U.S. FOIA (b) (6) was informed of the deficient practice at 3:50 PM during the Life Safety Code	K 347	1. Corrective action (a) A resident room fire /smoke detector program was implemented on 7/23/2024 (b) Smoke detectors were checked for functionality as part of the preventative maintenance program the smoke detector will be checked and results documented simi annually detector have 10 year sealed batterie 2. Residents with potentials to be affected by alleged deficient practice (a) All residents / staff had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur (a) The Regional Plants operation director has in-service the US FOIA (b)(6) on what to check for in his inspection and how to document his findings on 7/05/25 4. How to monitor corrective action (a) Smoke detector will be checked every 6 months and results documented simi annually detector have 10 year sealed batterry (b) The maintenance director will monitor and review at quarterly QAPI meeting 5. results will be submitted to quarterly QAPI Commiittee for revision and review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 347	Continued From page 7 exit conference. N.J.A.C 8:39-31.1(c), 31.2(e)	K 347		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation on 07/03/2024 in the presence of the facility U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101:2012 Edition, Section 19.3.5.1,Section 4.6.12,Section 9.7, NFPA 13:2010 Edition, Section 6.2.7.1 and NFPA 25:2011 Edition, Section 5.1.2.2.1. This deficient practice had the potential to affect all 147	K 353	1. Corrective Action/s (a) The maintenance director used NJ Ex (red fire stop to seal around the ceiling tile with pipe hole cutout (b) The maintenance Director used compress air to Blowout the buildup that was on the sprinkler head. 2. Residents with potentials to be affected by alleged deficient practice.	7/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 353	Continued From page 8 residents and was evidenced by the following: 1. At 8:40 AM, the surveyor and U.S. FO observed in the hallway between washing room and drying room, 2 of 2 sprinkler heads with excessive corrosion buildup. 2. At 8:42 AM, the surveyor and U.S. FO observed in the facility laundry washing room, 3 ceiling openings around conduit from over sized ceiling tile cuts compromising the smoke/fire resistant ratings. 3. At 8:45 AM, the surveyor and U.S. FO observed ceiling opening in the kitchen storage closet by the exit door to back of the building, compromising the smoke/fire resistant ratings. In an interview at the times, the U.S. FOIA (b) and U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 3:50 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K 353	(a) All residents / staff had the potential to be affected. 3. Systemic change to ensure alleged deficient practice does not recure (a) Regional director of Maintenance educated U.S. FOIA (b) (6) to inspect all ceiling tiles routingly to ensure there is breach of fire barrier. (b) Regional maintenance director educated Maintenance director to immediately fix and document any breach of fire barrier. 4. How to monitor corrective measure. (a) Maintenance director will inspect all ceiling tiles once weekly for as part of maintenance rounding. 5. Results will be submitted to quarterly QAPI committee meeting for review and revision.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist	K 363		7/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING **01** B. WING _____	**07/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 363	Continued From page 9 the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/03/2024 in the presence of the [redacted] and [redacted], it was determined the facility failed to ensure that corridor doors were maintained to positively latch in the frame and resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6.3. This	K 363	1. Corrective action (a) The Maintenance Department purchased and installed a positive passage latch on room 320 entrance door on 7/7/24 2. Residents with potentials to be affected	

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CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 363	Continued From page 10 deficient practice had the potential to affect all 147 residents and was evidenced by to following: Observations during a facility tour between 8:30 AM and 3:15 PM, revealed resident room #[NJ Ex C] door had no positive latching hardware. In an interview at the time, the [U.S. FOIA (b)] and [U.S. FO] confirmed the observation. The [U.S. FOIA (b) (6)] was informed of the deficient practice at 3:50 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e)	K 363	(a) All residents / staff had the potential to be affected 3. Systemic change to ensure deficient practice does not recur (a) A door audit was created and will be used monthly to inspect all resident room doors to ensure that they all latch correctly 4. The maintenance director will monitor and review at quarterly QAPI for the next 3 quarter	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/03/2024 in the presence of the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)], it was determined the facility failed to ensure all residents bathrooms exhaust fans observed were maintained in operational condition in accordance with NFPA 101:2012 Edition, Section 19.2.1,9.2. This	K 521	1. Corrective action/s (a) The Maintenance director with the assistant of the company technician troubleshoot the bathroom vents and found that there was bad belt that reduce the amount of suction in each bathroom on. (b) All belts were replaced on 7/7/24 and	7/23/24

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	315204	A. BUILDING **01** B. WING _____	**07/03/2024**

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K 521	Continued From page 11 deficient practice had the potential to affect all 147 residents and was evidenced by the following: Observations during a facility tour between 8:30 AM and 3:15 PM revealed all residents' bathrooms did not have windows and the exhaust fans did not operate when tested by the U.S. FO in the presence of the surveyor. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observations. The U.S. FOIA (b) (6) was informed of the deficient practice at 3:50 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e)	K 521	bathrooms now has full suction. 2. Residents with potentials to be affected by the. (a) All residents / staff had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur (a) A ventilation audit was created and the maintenance director or his designee will check and document the suction of all bathroom ventilation monthly. 4. How to monitor corrective action (a) The maintenance director will monitor and and inspect belts weekly for 12 weeks. 5. Result will be submitted to quarterly QAPI committee meeting for review and revision.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with	K 531		7/23/24

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CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE** **CEDAR GROVE, NJ 07009**

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K 531	Continued From page 12 Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 07/03/2024, the facility failed to ensure that 2 of 2 elevators were inspected and tested monthly in accordance with NFPA 101:2012 Edition, Section 19.5.3, 9.4.2, 9.4.3, 9.4.6 and 9.6.2, ASME A17-1 Safety Code for Elevators and Escalators:2004 Edition, Section 8.11.1.3. This deficient practice had the potential to affect all residents and was evidenced by the following: During review of records provide by the U.S. FOIA (b) (6)), revealed there was no record that Firefighter's Monthly Service Test on the elevators was performed and documented monthly. In an interview, the U.S. FO confirmed that the monthly Firefighter's Service Test was not currently being conducted and documented on a log. The U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code exit conference at 3:50 PM. N.J.A.C 8:39-31.2(e)	K 531	1. Corrective action (a) Monthly Firefighters elevator recall and phone test was performed and documented on 7/7/24. 2. Residents with potentials to be affected by alleged deficient practice. (a) All residents could potentially be affected. 3. Systemic change to ensure alleged deficient practice does not recur (a) Maintenance director was educated by the Regional Plants Operation director on How to Perform a monthly Firefighters elevator recall on 7/7/24. 4. How to monitor corrective action (a) A monthly elevator recalls, and firefighter test log was created and the maintenance director will to perform and document test monthly. (b) Regional Plants Operation director will audit log once monthly for 6 months. 5. Result of audit will be submitted to quarterly QAPI committee meeting for review and revision.	
K 914 SS=F	Electrical Systems - Maintenance and Testing	K 914		7/23/24

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K 914	Continued From page 13 CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview on 07/03/2024 in the presence of U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that non-hospital grade receptacles were tested at intervals not exceeding 12 months in accordance with NFPA 99:2012 Edition, Section 6.3.4.1.3. This deficient practice had the potential to affect all 147 residents. and was evidenced by the following: A review of the facility's electrical inspection reports provided by the U.S. FO[redacted] revealed the facility	K 914	1. Corrective action (a) The maintenance director had annual electrical inspection Done on 7-16-24 by atlas electrical. 2. Residents with potential to be affected by the alleged deficient practice (a) All residents / staff had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur	

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K 914	Continued From page 14 had no current annual inspection. The available report was dated 11/10/2022. In an interview, the U.S. FO confirmed the finding. The U.S. FOIA (b) (6) was informed of the deficient practice at 3:50 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 99	K 914	(a) US FOIA (b)(6) was educated on frequent review of safety schedule to ensure that Atlas Electrical (vendor) is notified on time to schedule inspection. 4. How to monitor corrective action (a) The maintenance director will review the life safety schedule regularly to ensure electrical inspection is done annually in addition to an internal audit of none hospital grade electrical outlet. (b) The maintenance director will monitor and review at quarterly QAPI for the next 3 quarter 5. Result will be submitted to quaerterly QAPI committee meeting for review and revision	
K 919 SS=F	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the emergency generator was equipped with a remote manual stop station in accordance with NFPA 110 Standard for Emergency and Standby Power Systems:2010 Edition, Section 5.6.5.6. This deficient practice had the potential to affect all 147 residents at the	K 919	1. Corrective action (a) The maintenance department has contacted NJ Ex Order 26.4b1 our emergency generator maintenance company to install a emergency stop in the hallways outside the generator room they are scheduled to	7/23/24

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K 919	Continued From page 15 facility and was evidenced by the following: An observation on 07/03/2024 at 9:25 AM revealed that emergency generator was not equipped with a Remote Manual Emergency Stop Switch anywhere on the premises. An interview at the time of observation, the U.S. FOIA (b) (6) confirmed the generator was not equipped with a manual stop station. The U.S. FOIA (b) (6) was informed of the deficient practice at 3:50 PM during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 99, 110	K 919	install this no later than august 2 2024. 2. Residents with potentials to be affected by alleged deficient practice (a) All residents / staff had the potential to be affected 3. Systemic change to ensure alleged deficient practice does not recur (a) US FOIA (b)(6) was educated by Regional Director of Maintenance on the need for emergency stop outside the generator room. 4. How to monitor corrective action (a) The maintenance director will ensure that installation is completed (b) Maintenance director will test the emergency stop button once a month then document with weekly run test. (c) The maintenance director will monitor and review at quarterly QAPI for the next 3 quarter 5. Result will be submitted to quarterly QAPI committee meeting for review and revision	
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	K 923		7/23/24

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K 923	Continued From page 16 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. 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 on 07/03/2024 in the presence of the facility U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure H-tank cylinders of compressed oxygen were stored in a safe manner that would protect it against tipping, and rupture in accordance with NFPA 99 and NFPA 101:2012 Edition, Section 8.7. This deficient practice had the potential to	K 923	1. Corrective action (a) The maintenance Director securely chained all 'H' tank cylinders to the wall on 7/3/24. 2. Residents with potentials to be affected by alleged deficient practice (a) All residents / staff had the potential to be affected.	

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K 923	Continued From page 17 affect all residents and was evidenced by the following: 1. At 10:06 AM on the second floor in oxygen storage area, the surveyor observed 2 H-tank cylinders that were not stored securely. 2. At 10:45 AM on the third floor in oxygen storage area, the surveyor observed 2 H-tank cylinders that were not stored securely. 3. At 11:10 AM on the fourth floor in oxygen storage area, the surveyor observed 2 H-tank cylinders that were not stored securely. In an interview at the time, the U.S. FOIA (b) and U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 3:50 PM. NJAC 8:39-31.2 (e) NFPA 99	K 923	3. Systemic change to ensure alleged deficient practice does not recur (a) All maintenance staff were educated on proper storage of 'H' tank cylinders by regional director of maintenance services on 7/3/24 4. How to monitor corrective action (a) The maintenance director will check oxygen storage daily for 4 weeks, weekly for 4 weeks and bi-weekly for 8 weeks to ensure oxygen is being properly stored. 5. result to be submitted to quarterly QAPI committee meeting for review and revision.	

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
315204 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/23/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE 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 K0211	07/23/2024	LSC K0293	07/23/2024	LSC K0321	07/23/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	07/23/2024	LSC K0347	07/23/2024	LSC K0353	07/23/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	07/23/2024	LSC K0521	07/23/2024	LSC K0531	07/23/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0914	07/23/2024	LSC K0919	07/23/2024	LSC K0923	07/23/2024
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	
7/3/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO