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 06/10/2021

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
F 000	INITIAL COMMENTS A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. Survey Date: 6/10/21 Census: 105 Sample Size: 21	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		7/30/21

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

Electronically Signed | 06/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a current copy of the advanced directive for a Do Not Resuscitate (DNR) was in the Resident's medical record. This deficient practice was identified for [redacted] of [redacted] residents (Resident #42) reviewed for advanced directives and was evidenced by the following: On 6/2/21 at 11:00 AM, Resident #42 was observed in the room with [redacted]. The surveyor reviewed Resident # 42's medical record. Resident #42 was [redacted] on [redacted] and [redacted] with diagnoses that [redacted] The surveyor reviewed the Resident's chart	F 578	Element#1 Resident # 42 had a [redacted] placed on the medical chart on [redacted]. [redacted] as a result in this deficient practice. Nursing Staff & Social Services were re-educated on Advance Directives and [redacted] by ADON. Element # 2 All residents have the potential to be affected. Element # 3 All resident's medical records were audited for appropriate order, sticker on chart and completed [redacted] on [redacted] Social Worker and or Designee will perform 5 audits on Advance	

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F 578	Continued From page 2 (paper medical records) that had a sticker placed on the inside opening of the binding cover of the chart. The sticker reflected that the Resident was a "[redacted]." A [redacted] A review of a form titled New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) located in the chart under the Advanced Directive tab, indicated wishes that included [redacted] (DNR) and as well as allowing natural death. The POLST was signed by the Resident's [redacted] on [redacted] On 6/8/21 at 11:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) taking care of Resident #42 who stated that the Advanced directive order can be found in the electronic Medical Record (eMAR). The LPN stated that in the case that the eMAR was offline, the nurses will then refer to the paper chart to check the code status of the Resident. The LPN acknowledged that the sticker affixed to the paper chart of Resident #42 should have been removed and replaced with DNR. On 6/8/21 at 1:30 PM, the surveyor spoke to the Administrator and the Director of Nursing (DON) regarding the above concern. The Administrator as well as the DON agreed that this was an oversight. They agreed that all information regarding a residents wishes for [redacted] should be updated and correct. No further information was provided regarding this [redacted] was provided.	F 578	Directive/POLST to identify any deficient practice relevant to advance directives weekly X 3, monthly X 2 then Quarterly x2. Element # 4 Findings will be reported to the Administrator to be presented to Quarterly QAPI meeting. Trends and concerns identified will be corrected and monitored for on-going compliance.	

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F 578	Continued From page 3	F 578		
F 658 SS=D	NJAC 8:39-4.1 (31) (iii) 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 that the facility failed to follow acceptable standards of practice for the care and treatment of a Executive Order 26, 4.b. [redacted], Executive Order 26, 4.b. [redacted] for 1 of 1 residents (Resident #17) reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	Element # 1 Resident # 17 was assessed on Executive Order 26, 4.b. [redacted] by Director of Nursing with Executive Order 26, 4.b. [redacted] noted as a result of this deficient practice. LPN identified received 1:1 education immediately on 06/08/2021 on the policy "Care and Treatment of Feeding Tubes" by the Director of Nursing. Pharmacy Consultant will perform a 1:1 observation on LPN involved in this deficient practice by 06/30/2021. Element # 2 All residents with Feeding Tubes have the potential to be affected. Element # 3 Nursing staff was immediately re-in-serviced on the policy "Care and Treatment of Feeding Tubes" by Director of Nursing and Nurse Educator on 06/11/2021 and on-going. Nurse Educator and or designee will complete a competency for nursing staff on the policy "Care and Treatment of	7/30/21

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F 658	Continued From page 4 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 case finding; 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." On 6/3/21 at 12:22 PM, the surveyor observed Resident #17 in bed with their eyes open. The resident did not acknowledge or respond to the surveyor. The surveyor observed a [redacted] at Resident #17's bedside that was not in use at the time. On 6/8/21 at 9:05 AM, the surveyor observed Resident #17 in bed positioned on their back with the head of the bed elevated. The feeding pump was alarming. There was a bottle of [redacted] Executive Order 26, 4.b. Executive Order 26, 4.b. On that same day at 9:10 AM, the Licensed Practical Nurse (LPN) entered Resident #17's room and stated that the resident had reached the total volume [redacted] to be administered for that day, so she was going to [redacted] Executive Order 26, 4.b. [redacted]. The LPN disconnected the [redacted]. The LPN filled a [redacted] Executive Order 26, 4.b. with water, inserted the tip of the [redacted] Executive Order 26, 4.b. into the resident's [redacted]. The LPN proceeded to use the plunger of the [redacted] to push the water through the [redacted]. It was then that the surveyor asked the LPN to stop what she was doing and to	F 658	Feeding Tubes" to be completed by 7/30/21. DON and or Designee will perform audits on nursing staff to identify any deficient practice on Gastrostomy tube care weekly X2, monthly X2, and quarterly X2. Element #4 Findings will be reported to the Administrator to be presented to Quarterly QAPI meeting. Trends and concerns identified will be corrected and monitored for on-going compliance.	

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F 658	Continued From page 5	F 658		

step out of the room. The surveyor asked the LPN if it was her routine practice to use the Executive Order 26, 4.b.. The LPN replied that she usually allowed it to flow in by gravity but sometimes it was "too thick" and needed a "little pressure." The surveyor asked the LPN what the facility's policy was regarding Executive Order 26, 4.b. flushes. The LPN replied, "to flush by gravity."

The surveyor reviewed the June 2021 Order Summary Report which reflected a Physician's Orders for Executive Order 26, 4.b. Executive Order 26, 4.b.) in the afternoon administer Executive Order 26, 4.b. Executive Order 26, 4.b.. There was an additional order to Executive Order 26, 4.b. and immediately following Executive Order 26, 4.b..

The surveyor reviewed the Admission Record which reflected that Resident #17 was Executive Order 26, Exec Executive Order 26, 4.b. with diagnoses Executive Order 26, 4.b.

The surveyor reviewed the Annual Minimum Data Sheet (MDS), an assessment tool, which reflected that Resident #17 was in a Executive Order 26, 4.b. Executive Order 26, 4.b.

The surveyor reviewed the Facility's "Care and Treatment of Feeding Tubes" policy and procedure dated 11/2017. The policy's statement reflected, "It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible."

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F 658	Continued From page 6 On 6/10/21 at 1:07 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing (DON) and Regional Nurse. The DON and Regional Nurse both acknowledged that all medications, feedings, fluids, and Flushes should be administered using a feeding pump or by gravity and never pushed in by pressure with a syringe plunger. No further information was provided.	F 658		
F 759 SS=D	NJAC 8:39-27.1 (a) Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Complaint # NJ141308 Based on observation, interview, and record review it was determined that the facility failed to maintain a medication error rate below 5%. The surveyor observed 3 nurses administer [redacted] of medication to 5 residents and there were 3 errors which resulted in a medication error rate of 9.68 %. The deficient practice was evidenced by the following: Error 1: On 6/4/21 starting at 8:45 AM, the surveyor	F 759	Element # 1 Resident # 72 was assessed by the Director of Nursing on [redacted] noted as a result in this deficient practice. On 6/4/21 Physician of resident #72 was made aware of the medication documentation error and an order was obtained to clarify the documentation of the medication administration. LPN # 2 received 1:1 counseling and education on “Medication Administration” policy on 06/04/2021 by ADON. Resident #38 was assessed by the Director of Nursing on [redacted] with [redacted] noted as a result of this deficient practice.	7/30/21

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F 759	Continued From page 7 observed the [redacted] Licensed Practical Nurse (LPN2) prepare medication for Resident #72. LPN2 placed medications,[redacted]) in a medication cup [redacted] that was documented on the screen of the Electronic Medication Administration Record (eMAR). LPN2 then administered the medication and signed for [redacted]. The surveyor discussed the documentation of the correct medication with LPN2, who agreed that she should have documented administering [redacted] on the [redacted]. Error 2 and Error 3: On 6/4/21 at 9:26 AM, the surveyor observed the 3rd floor Licensed Practical Nurse (LPN3) administer medication to Resident #38. LPN3 administered[redacted] A review of the documented administration time for these medications on the eMAR, revealed that the administration time was 8:00 AM. A review of the manufacturers recommendation for[redacted] stated that it should be administered before eating, preferably before breakfast. Breakfast is generally delivered at 8:00 - 8:10 AM to the [redacted]. The surveyor discussed the delay of the medication with LPN3, who stated that she was aware that the medication had to be administered	F 759	On 6/8/21 Physician of resident #38 was made aware of the [redacted] administration and that [redacted] were noted. A stat delivery of [redacted] was obtained [redacted] from the pharmacy. LPN # 3 received 1:1 in-service on the policy on “Medication Administration” policy 06/08/2021 by ADON. Nursing staff was immediately in-serviced on the “Medication Administration” policy by DON/Designee completed 06/08/2021. Element # 2 All residents have the potential to be affected. Element # 3 Nursing staff was immediately in-serviced on the “Medication Administration” policy by DON/Designee completed 6/8/2021. Nursing staff will be in-serviced on the “Re-Ordering Unavailable Medication” policy to be completed by DON/Designee by 7/30/21. DON and or Designee will perform audits on nursing staff to identify any deficient practice on Medication Administration weekly X 2, monthly X2, and quarterly X2. Element # 4 Findings will be reported to the Administrator to be presented to Quarterly QAPI meeting. Trends and concerns identified will be corrected and monitored for on-going compliance.	

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F 759	Continued From page 8 at 8:00 AM. She also informed the surveyor that she had a window of an hour before 8:00 AM or an hour after to administer the medication. LPN3 agreed that 9:26 AM was beyond the window of administration. LPN3 revealed that she was not aware that Executive Order 26, 4.b. needed to be administered before eating. On 6/8/21 at 2:17 PM, the surveyor discussed the medpass issues with the Director of Nursing and the Administrator. No further information was supplied. NJAC 8:39-29.2 (d)	F 759		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Complaint # NJ141308 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of cold food and drink served to the residents. This deficient practice was identified for 7 of 7 residents confirmed	F 804	Element#1 The 7 residents affected by this deficient practice were assessed by the Director of Nursing on Executive Order and Executive Order 26, 4.b. noted. All food items were immediately checked by the Food Service Director for proper holding temperatures on 6/3/21, no further	7/30/21

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F 804	Continued From page 9 during the lunchtime meal service on [Executive Order] for 3 of 3 nursing units [Executive Order 26, 4.b.] tested for food temperatures: On 6/3/21 at 11:38 AM, Surveyor #1 observed food truck arrive on the [Executive Order 26, 4.b.] Surveyor #1 pulled a tray from the 2nd food truck. Surveyor #1 along with the Ambassador of Dietary Services (ADS), observed the Registered Nurse and Certified Nursing Assistant (CNA) deliver meal trays to residents. After the last meal tray was delivered to a resident at 11:58 AM, the ADS stated that the thermometer was calibrated that morning and took the temperatures of the following items (regular consistency): (3) Meatballs with Low Sodium (LS) gravy 120.2 Degrees F ½ cup Mashed Potatoes 122.9 Degrees F 3/8 cup Roasted beets 99.0 Degrees F Butterscotch pie 63.8 Degrees F 6 oz cup coffee 135.1 Degrees F Surveyor #1 discussed the food temperatures with the ADS. The ADS informed Surveyor #1 that the temperatures should be above 140 Degrees F for hot foods and below 41 Degrees F for cold foods. The ADS further stated that he was, "very concerned and will be doing a full in service." On 6/3/21 at 12:01 PM, Surveyor #2 observed food truck arrive on the [Executive Order 26, 4.b.]. Surveyor #2 pulled a tray from the [Executive Order 26,] food truck. Surveyor #2 along with the ADS, observed the	F 804	concerns identified. The Dietary employees were re-in-serviced on Policy “Food: Quality and Palatability” by Food Service Director on 6/8/21. Element#2. All residents have the ability to be affected. Element#3 All staff will be re-educated by the Staff Educator on the “All Hands On Deck” procedure for tray pass on 7/12/21 and on-going. Test trays to be conducted x2 weekly for 4 weeks by FSD/Supervisor with immediate corrective action 7/5/21 and on-going. Food Service Director will present results of test tray assessment with any corrective actions taken to the Administrator weekly 7/8/21. The Administrator/Nursing Administration will complete walking rounds 3x weekly to monitor that the “All Hands On Deck Program” is effective, to begin 7/19/21 and on-going. Element#4 The Administrator will present the results of rounds to the QAPI Meeting monthly x3 months for review and recommendations, 7/29/21. The FSD will present the results of test tray assessment with any correction actions taken to the QAPI Meeting Monthly x3 months for review and recommendations, 7/29/21. Trends and recommendations identified will be	

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F 804	Continued From page 10 CNA deliver meal trays to residents. After the last meal tray was delivered to a resident at 12:09 PM, the ADS stated that the thermometer was calibrated that morning and took the temperatures of the following items (regular consistency): (3) Meatballs with LS gravy 121.9 Degrees F ½ cup Mashed Potatoes 122.5 Degrees F 3/8 cup Roasted beets 105.5 Degrees F 6 oz cup coffee 115.7 Degrees F Apple Juice 50.2 Degrees F On 6/3/21 at 12:03 PM, Surveyor #2 observed 2nd [redacted] food truck arrive on the [redacted]. Surveyor #2 pulled a tray from the 2nd food truck. Surveyor #2 along with the ADS, observed the CNA deliver meal trays to residents. After the last meal tray was delivered to a resident at 12:18 PM, the ADS took the temperatures of the following items (regular consistency): (3) Meatballs with LS gravy 119.4 Degrees F ½ cup Mashed Potatoes 124.5 Degrees F 3/8 cup Roasted beets 111.0 Degrees F 6 oz cup coffee 134.0 Degrees F Apple Juice 32.6 Degrees F Margarine 73.3 Degrees F	F 804	corrected and monitored to ensure compliance.	

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F 804	Continued From page 11	F 804		

Surveyor #2 discussed the food temperatures with the ADS. The ADS informed Surveyor #2 that the temperatures should be above 135 Degrees F for hot foods and below 41 Degrees F for cold foods.
The Ambassador further stated that he was, "very concerned" and would be doing a full inservice.

On 6/3/21 at 12:29 PM, Surveyor #3 pulled a tray from the food truck (Cart 1) on the [Executive Order 26, 4.b]. The surveyor along with the ADS, observed that the CNA immediately began distribution of meal trays to residents when the food truck reached the floor. The ADS was at the [Executive Order 26] floor nursing station along with the surveyor with a calibrated thermometer awaiting the distribution of the final tray.

On 6/3/21 at 12:35 PM, the last tray was delivered to a resident on the [Executive Order 2] floor. Surveyor #3 in the presence of the ADS, who had a calibrated thermometer to measure the temperature of the food, began taking the temperatures of the following items (regular consistency):

Coffee	104.0 Degrees F
Mashed Potato	129.6 Degrees F
Meatballs	131.0 Degrees F
Beets	120.0 Degrees F
Fresh Milk	49.0 Degrees F
Orange Juice	48.9 Degrees F

On 6/3/21 at 12:31 PM, Surveyor #3 pulled a tray from the food truck (Cart 2) on the [Executive Order 2] floor. The surveyor observed the CNAs delivering meal trays to residents.

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F 804	Continued From page 12	F 804		

On 6/3/21 at 12:45 PM, the last meal tray was delivered to a resident receiving meal trays from Cart 2, the ADS began taking temperatures of the following items (regular consistency) in the presence of surveyor #1:

Coffee	126.3 Degrees F
Mashed Potato	123.2 Degrees F
Meatballs	121.6 Degrees F
Beets	107.0 Degrees F
Pudding	49.4 Degrees F
Juice	49.2 Degrees F

On 6/3/21 at 12:34 PM, Surveyor #3 pulled a tray from the food truck (Cart 3) on the [redacted] floor. The surveyor observed the CNAs beginning the delivery of meal trays to residents at this time.

On 6/3/21 at 12:49 PM, the last meal tray was delivered to a resident receiving meal trays from Cart 3, the ADS began taking temperatures of the following items (regular consistency) in the presence of Surveyor #3:

Coffee	132.3 Degrees F
Mashed Potato	124.3 Degrees F
Meatballs	121.6 Degrees F
Beets	120.0 Degrees F
Juice	58.6 Degrees F

On 6/3/21 at 12:50 PM, the Surveyor #3

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F 804	Continued From page 13 interviewed the ADS who agreed that the temperatures of the food were not maintained at an appetizing temperatures to the residents. On 6/3/21 at 2:30 PM, the surveyors met with the facility Administrator and Director of Nursing to discuss the food temperature discrepancy. The Administrator agreed that the hot food should be hotter and the cold food colder. No further information was supplied. A review of Food and Drug Administration guidelines for maintaining foods at safe temperatures document, at or below 41 degrees F (for cold foods) or at or above 135 degrees F (for hot foods). NJAC 8:39-17.4(e)	F 804		
F 812 SS=D	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	F 812		7/30/21

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F 812	Continued From page 14 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain appropriate kitchen sanitation practices and sanitary environment to prevent the development of food borne illness. This deficient practice was evidenced by the following: On 6/1/21 at 10:30 AM, during a tour of the kitchen, the surveyor, along with the Dining Services Director (DSD), Ambassador of Dietary Service (ADS) and the facility Dietician, the surveyor observed the following: 1. In the rack where the dry pots and pans were placed, there were 7 food pans/trays that were observed to be wet nesting and stacked together. Wet-nesting occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow. FDA guidelines mandate that all wares should be air dried. Using towels to dry dishes is never permitted. 2. The drying rack was placed right next to the dishwasher machine exposing the dry pots and pans of water splash from the dish machine. The DSD acknowledged that the containers of food must be stored or protected from the contamination including protection from water splash. 3. The high temperature dishwasher was observed with a temperature of 140 degrees	F 812	Element#1 Food pans/trays found wet nesting and stacked together were immediately removed, cleaned, and sanitized and properly air dried: 6/1/21 by Food Service Director. All areas of the kitchen were inspected for wet nesting by Kitchen management 6/1/21 no concerns noted. The drying rack was relocated to a separate area in the kitchen and 2 additional racks were added to ensure propre drying process: 6/1/21 by the Food Service Director. All areas of the kitchen were inspected by Kitchen management to ensure containers of food were stored or protected from the contamination including protection from water splash 6/1/21, no concerns noted. The dish machine reached proper temperatures on 6/1/21 and on-going. The dish machine was monitored for proper temperatures with temperatures logged with each meal service by staff operating the dish machine to ensure proper temperatures were reached 6/1/21. Element#2 All residents have the ability to be affected. Element#3	

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F 812	Continued From page 15 Fahrenheit (F) during the wash cycle. The ADS instructed the dishwasher to run the dishwasher four times with the temperature that remained at 140 degrees F. The DSD stated that the temperature should have reached to 150 degrees F as recommended by the Food and Drug Administration food code. A review of an updated facility policy titled, "Pots and Ware Washing" reflected under "Storing Clean Dishes, Service ware and Utensils", to store clean dishes, service ware, utensils, and equipment out of the way of kitchen traffic. They should be covered or otherwise protected from dirt and condensation. On 6/2/21 at 2:00 PM, the surveyor discussed the above concern to the Administrator and the Director of Nursing. No further information was presented. NJAC 8:39-17.1(a);17.2(g)	F 812	All Dietary Staff were in-serviced on the Pots and Warewashing Policy, which includes wet nesting and dish machine temperatures, by 6/15/21 by the FDS Director. Using the Opening & Closing Checklist the FSD or designee will monitor for proper drying procedures, by 7/5/21 and on-going. Using the Opening & Closing Checklist the FSD will monitor to ensure containers of food are stored or protected from the contamination including protection from water splash, by 7/5/21 and on-going. Food Service Director staff or designee will inspect the dish machine on daily rounds to ensure it is reaching proper temperature. Maintenance will address any problems identified by 7/5/21 and on-going. Monthly an outside contractor, will inspect the dish machine including proper calibration of temperatures beginning July. Element#4 Results of daily Opening & Closing Checklist will be reported by the Food Service Director to the QAPI Committee Meeting monthly x3 months for review and recommendation. Trends and recommendations identified will be corrected and monitored for compliance. The Food Service Director will report results of daily inspections of the dish machine to the QAPI Committee Meeting x3 months for review and recommendations. Trends and recommendations will be corrected and monitored for compliance.	

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F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to properly dispose and maintain waste in the garbage compactor area as evidenced by the following: On 6/1/21 at 11:00 AM, in the presence of the Dining Services Director (DSD), Dietician and Ambassador of Dietary Service (ADS) the surveyor observed the garbage compactor area to be littered with soiled plastic gloves on the ground by the opening of the dumpster, old empty water bottles and dirty wood pellets. The dumpster was also observed to have a strong foul odor, white colored residue stains on the ground with flies hovering around the area. The DSD stated to the surveyor that the area was supposed to be cleaned with a power washer when needed, at least twice weekly. There was no documented cleaning schedule available for review. The ADS and the DSD both stated that the dumpster area needed to be cleaned. On 6/1/21 at 1:30 PM, the surveyor informed the Administrator, and the Director of Nursing regarding the above concern. No other information was presented. NJAC 8:39-31.5(a)1	F 814	Element#1 No residents were affected by this deficient practice. On 6/1/21 the facility dumpster area was cleaned of clutter and debris and power washed by the Director of Maintenance. On 6/8/21 the Extermination Company treated the dumpster area. Element#2 All residents have the ability to be affected. Element#3 The Dietary and Housekeeping employees will be re- in-serviced on the "Dumpster Policy" by 7/5/21. Daily the Dietary Director and Housekeeping Management will observe the dumpster area for odors, stains, and debris and/or clutter surrounding the dumpster. If the area is not clean, it will be cleaned immediately; 6/11/21. The Extermination Company will include the dumpster area into their monthly visit for treatment as necessary began 6/22/21 and on-going. Dietary Director will present observations and follow up daily in Morning Report for 3 months; 6/11/21. The Maintenance Director will complete walking rounds 3x weekly to monitor that the dumpster area is free of odor and	7/30/21

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F 814	Continued From page 17	F 814	stains and clear of debris and/or clutter surrounding the dumpster area. To begin 7/1/21 and on-going. Element#4 The Maintenance Director will present the results of rounds to the QAPI Meeting monthly x3 months for review and recommendations. Trends and recommendations identified will be corrected and monitored to ensure compliance.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		7/30/21

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F 880	Continued From page 18 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 19 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain proper infection control practices for 1 of Executive Order 26, 4.b. and 1 of 1 Residents reviewed for Executive Order 26, 4.b.; Resident #89. This deficient practice was evidenced by the following: On 6/2/21 at 11:32 AM, the surveyor observed Resident #89 in bed calling out for assistance. The surveyor observed an Executive Order 26, 4.b. at Resident #89's bedside, turned on, with the Executive Order 26, 4.b. set at Executive Order 26, 4.b.. The surveyor observed that one end of the Executive Order 26, 4.b. Executive Order 26, 4.b. but the supply tubing which consisted of Executive Order 26, 4.b. attached to the Executive Order 26, 4.b.) used to Executive Order 26, 4.b. Executive Order 26, 4.b. At that time, the Licensed Practical Nurse (LPN) entered Resident #89's room and stated she was currently on orientation, working at the facility only a short time. The LPN picked up the Executive Order 26, 4.b. wiped it with a dry paper towel , placed it back into the resident's Executive Order 26, 4.b. and quickly left the room. The surveyor identified the above observation and concern to the attention of the LPN in the presence of the Registered Nurse (RN), who stated that she was responsible for training and orienting the LPN. The RN stated that the LPN should have thrown out the Executive Order 26, 4.b. and replaced it with a Executive Order 26, 4.b. The LPN replied,	F 880	Element # 1 Resident # 89 was assessed by the ADON on 06/02/2021 with Executive Order 26, 4.b. Executive Order 26, 4.b. noted as a result of this deficient practice. LPN received 1:1 education by the Director of Nursing on following appropriate infection control practices on oxygen equipment on 06/02/2021. Resident # 20 was assessed by the ADON on 06/04/2021 with no adverse effects as a result of this deficient practice. LPN # 4 received 1:1 education by the Director of Nursing on following appropriate Infection control practices and COVID-19 Compliance on Quarantine on 06/04/2021. Element # 2 All residents have the potential to be affected by this deficient practice. Element # 3 Nursing staff was immediately in-serviced on the Infection Control Practices and Policies by DON/Designee on 06/15/2021 and on-going. DON and or Designee will perform audits on nursing staff to identify any deficient practice on Infection Control weekly X 2, monthly X2, and quarterly X2. Element # 4 Findings will be reported to the	

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F 880	Continued From page 20 "I wiped it with a paper towel." The RN told the LPN, "you should have thrown it out." After speaking to the RN, the LPN acknowledged that she should have thrown the Executive Order 26, 4.b. that was Executive Order 26, 4.b., in the trash. The surveyor reviewed the June Physician Order Summary (POS), which reflected a Physicians' order (PO) to administer Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.((Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. and a PO to Executive Order 26, 4.b. and to the if it touches a contaminated surface. The surveyor reviewed the Executive Order 26, 4.b. Record which reflected Resident #89 was Executive Order 26, 4.b. The surveyor reviewed the Admission Minimum Data Set (MDS), an assessment tool, dated , which reflected the Resident's Executive Order 26, 4.b. Executive Order 26, 4.b. " The surveyor reviewed the facility's "Oxygen Safety" policy and procedure dated 1/1/12 and updated 11/2017. The policy's statement reflected, "It is the policy of this facility to provide a safe environment for residents, staff and the public. This policy addresses the use and storage of oxygen and oxygen equipment." The policy did not address proper use/ storage or disposal of oxygen supply tubing.	F 880	Administrator to be presented to Quarterly QAPI meeting. Trends and concerns identified will be corrected and monitored for on-going compliance. DPOC Root Cause Analysis was completed. LPN had a break in infection control protocols not being followed due to inconsistent observation by staff. Top Line Staff and Infection Preventionist reviewed CDC TRAIN Module 1 - Infection Prevention & Control Program. Front line staff reviewed CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff; Keep COVID-19 Out!	

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F 880	Continued From page 21	F 880		

On 6/2/21 at 1:56 PM, the survey team discussed the above observations with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON stated that the LPN should have Executive Order 26, 4.b. and further stated she would be doing immediate Infection Control Education with the LPN.

On 6/4/21 at 9:50 AM, the surveyor observed the Executive Order 26, Licensed Practical Nurse (LPN4) taking Resident #20's vitals Executive Order 26, 4.b. Executive Order 26, 4.b. in the resident's room. The surveyor noted that there was a Personal Protective Equipment (PPE) bin outside of Resident #20's room. LPN4 was observed in Resident #20's room not wearing proper PPE, no gown, gloves or face shield, only wearing an N-95 mask.

On 6/4/21 at 9:57 AM, LPN4 exited Resident #20's room and was observed using hand sanitizer to clean her hands. The surveyor discussed the presence of the PPE bin in front of Resident #20's room with LPN4, who responded, that Resident #20 is Executive Order 26, 4.b. Executive Order 26, 4.b. and no PPE needed to be worn. The surveyor then pointed out that the signage posted on Resident #20's door stated, "STOP DROPLET PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room and wear a surgical mask." The surveyor also pointed out a second sign posted on the door reading, "STOP CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. Put on gloves before entry. Discard gloves before room exit. Put on gown before entry. Discard gown before room exit." LPN4 stated that the PPE bin along with the

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F 880	Continued From page 22 signage should have been removed from the entrance to Resident #20's room. On 6/4/21 at 10:00 AM, the surveyor and LPN4 reviewed Physician orders (PO) for resident #20. There were no orders [redacted] Resident #20 Executive Order 26, 4.b.. The surveyor along with LPN4 noted a PO dated [redacted] that read, "Observe DROPLET and CONTACT PRECAUTIONS Perform Hand Hygiene before entering and leaving room. Maintain N-95 mask or face mask (if N-95 unavailable) and eye protection at all times when in resident room. Use gloves and gowns during high contact care activities (ex toileting, dressing, device care). Every shift for COVID-19 Precautions for 14 days." On 6/4/21 at 10:08 AM, another Licensed Practical Nurse informed LPN4 that Resident #20 would complete the Executive Order 26, 4.b. The Licensed Practical Nurse informed LPN4 that when she entered Resident #20's room she would have to wear an N95, surgical mask on top of the N95, gloves, gown and remove all but the N95 prior to leaving the room. On 6/4/21 at 10:10 AM, the surveyor interviewed Resident #20 who stated that they were not Executive Order 26, 4.b. Resident #20 explained that they had Executive Order 26, 4.b. and the resident's physician did not feel that the vaccine was safe for the resident at this time. A review of the [redacted] Sheet (Executive Order 26, 4.b. [redacted] revealed that Resident #20 was Executive Order 26, 4.b. Executive Order 26, 4.b.	F 880		

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Executive Order 26, 4.b. [redacted].

On 6/4/21 at 11:20 AM, the surveyor interviewed the Staff Educator Registered Nurse (SERN) who stated that Resident #20 Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. [redacted]. Resident #20 was also on droplet precaution due to a Multi-Drug Resistant Organism (MDRO) infection. The SERN stated that LPN4 should have worn her N95, a surgical mask (protecting the N95), a gown, gloves and eye protection (shield or goggles) when entering the Resident's room. The SERN also stated that LPN4 should have removed all the PPE but left on the N-95 mask prior to leaving the room and washed her hands before continuing any other activity in the facility.

On 6/4/21 at 10:56 AM, the surveyor informed the Administrator of the incident that occurred with LPN4. The Administrator stated that Resident #20 was still on Executive Order 26, 4.b. The Administrator added, "Any resident that comes from the hospital is put on a Executive Order 26, 4.b. The Administrator included that all PPE should worn when caring for any resident that is on quarantine in the facility.

On 6/4/21 at 12:00 PM, the surveyor interviewed the Infection Control Preventionist Nurse Practitioner (NP) who stated that LPN4 should have worn her N95, a surgical mask (protecting the N95), a gown, gloves and eye protection (shield or goggles) when entering the Resident's room. The NP added that LPN4 should have removed all the PPE, including the surgical mask

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 06/10/2021

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
F 880	Continued From page 24 prior to leaving the room and washed her hands before continuing any other activity in the facility. The NP also explained that Resident #20 is still [redacted]. The surveyor reviewed the facility policy, "Considerations for Cohorting COVID-19 Residents." Review of section "(b) Yellow Zone" documented, "This cohort serves as an observation area where persons are observed and monitored for symptoms that may be compatible with COVID-19. This cohort consists of :a. All unvaccinated persons from the community or other healthcare facilities who are newly or readmitted. These persons remain in the YELLOW ZONE for 14 days to monitor for symptoms that may be compatible." On 6/4/21 at 2:50 PM, the surveyor team discussed this and other findings with the DON and LNHA, no further information was supplied or presented. NJAC 8-39-19.4 (a)	F 880		

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	8/4/2021 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 F0578	Correction	ID Prefix F0658	Correction	ID Prefix F0759	Correction
Reg. # 483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	07/30/2021	LSC	07/30/2021	LSC	07/30/2021
ID Prefix F0804	Correction	ID Prefix F0812	Correction	ID Prefix F0814	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.60(i)(4)	Completed
LSC	07/30/2021	LSC	07/30/2021	LSC	07/30/2021
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/30/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/10/2021	☐ YES ☐ NO