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 04/11/2025

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 Complaint #: NJ00178559 Census: 140 Sample Size: 3 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		

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

Electronically Signed | 04/28/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060729	A. BUILDING: _____ B. WING _____	C 04/11/2025

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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on facility document review on 04/11/2025, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 13 of 14 day shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. Corrective Action: (a) A new staffing Agency was engaged in March to complement existing Agency. (b) A new and more effecting staffing company "Pinpoint" was also engaged to ensure adequate referral for applicants for advertised open position. (c) Staffing coordinator was educated on 'Making Administrator, DON and Nursing management aware of potential staffing shortage 72 hours in advance" by the administrator. (d) Staffing Agency was engaged and contract signed on 10/08/24. Agency will provide additional staff to building	4/28/25

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

Electronically Signed | 04/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060729	A. BUILDING: _____ B. WING _____	C 04/11/2025

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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S 560	Continued From page 1 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 03/23/2025 to 03/29/2025 and 03/30/2025 to 04/05/2025. The facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -03/23/25 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -03/24/25 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/25/25 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/26/25 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/27/25 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -03/28/25 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. -03/29/25 had 14 CNAs for 140 residents on the	S 560	whenever the need arises. (e) Staffing was reviewed by the Director of Nursing and Administrator; no residents were affected negatively by the deficient practice. 2. Residents with potentials to be affected by alleged deficient practice. (a) All residents can potentially be affected by alleged deficient practice. 3. Systemic change/s to ensure alleged deficient practice doe not recur. (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 - Best Care College - 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.	

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	060729	A. BUILDING: _____ B. WING _____	C 04/11/2025

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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S 560	Continued From page 2 day shift, required at least 17 CNAs. -03/30/25 had 12 CNAs for 139 residents on the day shift, required at least 17 CNAs. -03/31/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/01/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/02/25 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/04/25 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -04/05/25 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs.	S 560	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 consecutive months, the plan will be amended as needed.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060729 Y1	A. Building B. Wing Y2	4/29/2025 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 04/28/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 4/11/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: X4O312

STATE FORM: REVISIT REPORT (11/06)