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	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury at Cedar Grove	398 Pompton Avenue Cedar Grove, NJ 07009

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint Intake ID #: 2585781Based on interview, record review, and review of facility documents on 11/12/25 and 11/13/25, it was determined that the facility failed to notify the New Jersey Department of Health (NJDOH) and the Office of the Ombudsman immediately or within two hours of the identification of an injury of unknown origin in accordance with Federal and State laws and the facility's Abuse policy. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed for abuse. This deficient practice was evidenced by the following:On 11/12/25 at 10:50 AM, the surveyor reviewed the closed Electronic Medical Record (EMR) of Resident #1. A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to; unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, and difficulty in walking, not elsewhere classified. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool, dated 7/10/25, included the resident had a Brief Interview for Mental Status (BIMS) score of 00, which indicated that the resident was severely, cognitively impaired. Further review of the MDS revealed that the resident received hospice services. A review of the resident's individual comprehensive care plan (ICCP) included a focus area, initiated on 7/29/25, with a revision date of 8/8/25, included: Resident #1 is at risk for skin alteration r/t (related to) their own restlessness, impulsiveness and agitation. Resident #1 has a skin tear and abrasion to the forehead on 7/29/25. Laceration to left lower limb 8/7/25. Interventions included: Hospice HHA (Home Health Aide) was DNR (do not return) pending investigation (initiated 7/31/25). Send to hospital for evaluation/tx (treatment) (initiated 8/7/25). Wrap bilateral lower extremities with cling wrap daily and monitor (initiated 8/7/25). A review of the Order Summary Report (OSR), dated as of 8/6/24, included the following physician's order (PO):A review of a PO, dated 7/30/24, revealed Ace Wrap to bilateral lower extremities every morning and at bedtime for edema (swelling). Put on in the morning and remove at night.A review of the August 2025 Medication Administration Report (MAR) revealed a PO with a start date of 7/30/24 at 11:00 PM, and a D/C (discontinue) date of 8/7/25 at 2:47 PM, for ace wrap to bilateral extremities every day and night shift for edema on in am and off at hs (hours of sleep). The entry was signed out as administered on 8/6/25 on both the day and night shifts. A review of the Progress Notes (PN) included a Health Status Note (HSN) dated 8/7/25 at 8:06 AM, revealed, Hospice Care: Resident was received in bed asleep in a supine position and responsive with no distress noted. At about 2 AM, during routine rounds, resident was observed lying in bed grimacing and moaning softly. Respirations shallow at 22/min (per minute), pulse 85 bpm (beats per minute), BP (blood pressure) 126/81 mm/hg (millimeters of mercury), O2 sat 97% on room air. Administered Lorazepam (antianxiety medication) 0.25 ml (milliliters) sublingual (administered under the tongue) for anxiety and restlessness. Administered Oxycodone (an opioid pain medication) 0.25 ml oral solution for pain/comfort, safety/fall precautions maintained, bed to the lowest. A further review of the PN included a HSN dated 8/7/25 at 4:51 PM, revealed, During morning rounds this nurse noticed resident with a laceration to their left inner lower leg. The 11-7 nurse was notified and came to assess resident. When assessed, resident linear (straight line) laceration measures 6.5 x 1 and 1 cm (centimeter) deep. DON (Director of Nursing), Hospice, MD (Medical Doctor), and family made aware. New order for Mupirocin (antibiotic ointment) BID (twice a day) to L (left) inner lower leg. Open area was cleaned and followed by MD order and was covered with a clean dry dressing. Wrap b/l lower legs. Further review of the PN revealed a HSN dated 8/7/25 at 7:23 PM, Patient transferred out to hospital [name redacted] due to laceration on left leg. Patient left facility @ 4:23 PM via.transport. A further review of the PN included a HSN dated 8/8/25 at 8:19 AM, revealed, At 6 AM, resident returned from .hospital via stretcher awake and responsive with no respiratory distress noted. Resident had a laceration to left tibia (shin bone) closed with 7 (seven) sutures. Sutures appear intact, wound edges well-approximated. Minimal serosanguinous (clear with red tinge) drainage noted on dressing. Surrounding skin slightly erythematous (reddened), no swelling or purulent discharge observed.Resident was placed on a one to one (observation), bed to lowest position. MD and family [name redacted] made aware that resident is back to the facility. Resident will continue to be assisted with needs and monitored for falls.On 11/13/25 at 11:54 AM, the surveyor reviewed a Reportable Event Record/Report (RER/R) which indicated that a Significant Event was called into the NJDOH on 8/28/25 at 5:55 PM, for a Significant Event that occurred on 8/7/25 a 7:00 AM, 21 days later. Further review of the RER/R revealed that on 8/7/25 during morning rounds the resident was found to have a laceration to the inner, left lower leg measuring 6.5 cm x 1 cm x 0.25 cm Further review of the RER/R revealed that an