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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44605 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 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 Styrofoam plates and cups, with plastic utensils. The surveyor further observed the residents who were eating in their rooms also having Styrofoam plates and cups, with plastic utensils. The surveyor interviewed Certified Nursing Assistant (CNA #1), who stated that Styrofoam 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 Styrofoam 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 Styrofoam 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 Styrofoam 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 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. (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/28/24 at 09:34 AM, the surveyor interviewed the Food Service Director (FSD), who confirmed the dish machine has not worked for the last 5 or 6 weeks. The FSD 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 FSD 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 Licensed Nursing Home Administrator (LNHA), who stated he has sent multiple emails to corporate regarding the dish machine repair. Tha LNHA 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 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 LNHA, Director of Nursing, Regional Clinical Registered Nurse, and Regional Infection Preventionist/Registered Nurse. The LNHA provided copies of emails sent to corporate regarding the dish machine. The LNHA 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)

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48964 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, 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 Administrator. This item was noted to have the Staff Initials RP 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 Director of Recreation (DoR), 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 DoR further stated that the facility's Licensed Nursing Home Administrator (LNHA) was in charge of the survey binder. On 06/28/24 at 10:53 AM, the surveyor interviewed the Unit Manager 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 LNHA 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. 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. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 1:26 PM, the surveyor spoke with the facility's LNHA, Director of Nursing, Regional Clinical Registered Nurse and the Regional Infection Preventionist. 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 LNHA 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. N.J.A.C. 8:39-9.4(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39399 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 resident-to resident physical altercation. 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: 1. On [DATE] 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 [DATE] and documented an event that occurred on [DATE] at 9:00 PM involving Resident #36 and Resident #299. The report documented Resident #299 was observed by the staff holding Resident #36 and was hurting the resident. The residents were separated immediately by the staff who witnessed the incident. The report concluded, Based on witness statement and both residents account, Resident #299 annoyed Resident #36 by setting off the alarm while trying to open the exit door. Resident #299 on the other hand was provoked by Resident #36's attempt to get him to stop pushing the door. Resident #299 escalated the verbal altercation to physical altercation. 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 Schizophrenia. A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated [DATE] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated that the resident had moderately impaired cognition. A review of Resident #36's interdisciplinary care plan with a revision date of [DATE] included a care plan titled, The resident has potential to demonstrate verbally abuse behaviors . A review of Resident #229's AR indicated the resident was admitted to the facility with diagnoses that included but was not limited to Unspecified Psychosis. Further review of the resident's hybrid medical record revealed that the resident expired in the facility on [DATE]. A review of the Q/MDS an assessment tool used to facilitate the management of care, dated [DATE] reflected that the BIMS score was not obtained due to severely impaired cognition. A review of Resident #299's interdisciplinary care plan with a revision date of [DATE] included a care plan titled, [Resident #299] has potential to demonstrate physical behaviors related to diagnosis of dementia with behavioral disturbances . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:33 PM, the surveyor interviewed the facility's Licensed Nursing Home Administrator (LNHA) who confirmed the details of the incident that took place on, Saturday, [DATE]. The LNHA stated the incident happened on a weekend and the Reportable Event Record/Report Form was not reported to the NJDOH until Monday, [DATE]. The facility could not provide any documentation of the resident-to-resident 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. 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 [DATE] at 10:44AM, the surveyor informed the facility's LNHA, Director of Nursing, Regional Clinical Registered Nurse and Regional Infection Preventionist regarding the above concern. The LNHA 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. N.J.A.C. 8:,d+[DATE].1(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 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 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 Dementia with behavior. A review of the Quarterly MDS (Q/MDS), dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 03 out of 15, indicating that the resident had severe cognitive impairment. Further review of the Q/MDS Section D Mood under Section D0150 Resident Mood Interview (PHQ-2-9) which reflected that the interview was conducted and signed on 4/21/24, 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 April 2024 electronic Medication Administration Record (eMAR) revealed a physician's order which indicated, Resident is on (Zoloft) for indication of (Hitting striking out, flipping furniture) for (depression) every shift Target behavior observed of flipping furniture, Wandering at night. The listed behaviors were observed on April 22, 23, and 24, 2024, as indicated in the eMAR. A review of the 4/24/24 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, alert, and oriented, able 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 Multiple Sclerosis (disease of the brain and spinal cord). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Annual MDS (A/MDS), dated [DATE], reflected that the resident had a BIMS score of 14 out of 15, indicating that the resident had intact cognition. Further review of the Q/MDS Section D Mood under Section D0150 Resident Mood Interview (PHQ-2-9), which reflected that the interview was conducted and signed on 4/17/24, three (3) days before the ARD. On 6/28/24 at 9:40 AM, the surveyor interviewed the facility's Social Worker (SW), who was responsible for completing Section D and Section E in the MDS assessments. The SW stated that he had been interviewing the residents for Section D screening at least 2-3 days before the ARD. The SW also confirmed that the lookback period to complete Section D must be 14 days before the ARD. The SW did not provide any further information as to why he was doing the interview before the indicated ARD. The SW added that Resident #16's behavior, documented in the April 2024 eMAR, should have been coded under Section E0200A. On 6/28/24 at 9:06 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that the Section D Mood interview completed by the SW should have been a 14-day look-back period from the date of the ARD. The MDSC/RN 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 Licensed Nursing Home Administrator, Director of Nursing, Regional Clinical Nurse, and Regional Infection Preventionist. No further information was provided. NJAC 8:39-33.2(d)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 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 safe smoking. This deficient practice was identified for 1 of 29 residents reviewed for resident-centered care plans (Resident #350), and was evidenced by the following: The Admission Record (AR) indicated that Resident #350 was admitted to the facility with the diagnoses which included but was not limited to Bipolar Disorder and Seizure Disorder. The Admission Minimum Data Set (A/MDS), an assessment tool that facilitates resident care, dated 06/06/24 reflected that the resident was cognitively intact and required supervision with activities of daily living. On 06/26/24 at 10:52 AM, the surveyor interviewed Resident #350 who was outside the facility for coffee social. The resident stated that they had been in the facility for approximately three weeks. Resident #350 stated they enjoyed the recreation department and liked to attend the activities that the facility provided. The resident indicated that they had smoked, and that smoking was permitted in a designated areas. The resident stated that the facility had a smoking schedule wherein residents were permitted to smoke at 09:30 AM, 01:15 PM, 04:15 PM, and 05:30 PM. The resident further stated that the staff held the cigarettes, vapes and lighters when not in use. The resident further stated that the staff monitors the smokers during the scheduled smoking times. Resident #350 stated the facility performed a smoking assessment to ensure that the resident was a safe smoker. The resident stated that they started smoking soon after being admitted to the facility. The surveyor reviewed the form titled, Smoking Contact and Smoking Assessment for Resident #350 dated 06/04/24, which revealed that Resident #350 required supervision during smoking and there was a CP initiated for safe smoking. The surveyor reviewed Resident #350's list of CP and there was no documentation that a CP was implemented for safe smoking. Progress notes reflected the following: On 6/25/2024 at 16:52 (04:52 PM) Smoking and Safety status Resident uses vape products and has anxiety and Chain smokes. On 06/27/24 at 09:27 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who explained that when a resident was admitted to the facility, the nurse was responsible to complete the smoking assessment upon admission. The LPN further stated that it would be important to complete the assessment immediately to ensure that the resident was safe to use a cigarette smoke, and also for the resident to have the right protective equipment such as a smoking apron. The LPN added that it would be important to ensure the CP was implemented to include safe smoking with safety interventions. The LPN added that the CP was a communication tool which provided information on how to care for a resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/27/24 at 09:45 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) on the third floor who explained that when a resident was admitted to the facility and were a smoker, the smoking assessment must be completed upon admission. The LPN/UM stated that the smoking assessment must be completed so that the resident who smoked had the proper interventions in place to ensure safety and to determine if the resident was an independent smoker. The LPN/UM confirmed that a CP must 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 Certified Nursing Assistant (CNA) who had been employed in the facility for [AGE] years. The CNA stated that Resident #350 went out to smoke with supervision of the staff from activities department. The CNA added that there had been no incidents or accidents reported regarding the resident smoking. 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 about 7 months. LPN/UM #1 explained that if a resident smoked, a physician's order must be obtained, and a smoking assessment must be completed upon admission to the facility. The LPN/UM#1 further explained that a smoking 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 smoking 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 safety smoking interventions. The assessment included what CP interventions must be in place. She confirmed that the CP should have been implemented to include safe smoking for Resident #350. On 06/27/24 at 10:06 AM, the surveyor 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 safe to smoke and if any interventions should be implemented to ensure that the resident was safe during smoking times. She stated that a CP must be initiated for safe smoking 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 safe smoking when the smoking assessment was completed on 06/04/24. On 06/27/24 at 10:17 AM, the surveyor interviewed the Director of Recreation and the Activities Assistant who both agreed that when a safe smoking assessment was completed on 6/4/24 , a CP should have been implemented to include that the resident smoked. 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 Licensed Nursing Home Administrator, Director of Nursing, Regional Clinical Nurse, and Regional Infection Preventionist and discussed the above concern. No further information was provided. NJAC 8:39-11.2(i)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858 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 code status (the type of emergency treatment a person would or would not receive if their heart or breathing were to stop) for Resident #101, #146. 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 [DATE] at 11:06 AM, the surveyor observed Resident #46 in bed. The resident stated they were missing their left hearing aid (HA) and that staff was aware. The resident further stated It has been missing for about 2 months. The resident told the surveyor that staff was aware and so was the Unit Clerk (UC). The surveyor reviewed the electronic Medical 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: Type 2 Diabetes Mellitus with other Circulatory complications, Cerebral Ischemic attack, unspecified, and End Stage Renal Disease. A review of the Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. A review of the resident's Care plan revealed a focus titled,: Risk for Impaired Communication r/t (related to) bilateral hearing deficient, Date Initiated: [DATE]. Further review revealed: Intervention: Ensure hearing aides are placed while awake and put to charge at night, Date Initiated: [DATE]. (continued on next page)

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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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Physician Order Summary revealed a PO for: Hearing aid to (bilateral) ears ON in AM and OFF in PM Red for right ear and Blue for left ear. every day and night shift for hearing loss, dated [DATE]. A review of the facility provided form titled, Grievance Form dated [DATE] for Resident #46 revealed: Summary of Concern: The resident reported that [identifier redacted] left ear hearing aid is missing and that it is the side [identifier redacted] needs the most. Further review revealed: Resolution: The resident and family have been notified of all the facility's attempt to locate the missing left hearing aid. Insurance was contacted for replacement. A review of progress notes revealed a Health Status Note dated [DATE] at 16:35 (4:35 PM) Note Text: Searched for reported missing left ear hearing aid in the resident's room and around roommate's [NAME] as requested, and non-found. [Name redacted] made aware of the comprehensive search. Also, the NP (nurse practitioner) completed another search on her own of the resident's room and the roommate. And was not able to locate. Housekeeping director searched as well of the laundry area and could not find the missing hearing aid. [name redacted] denied taking the hearing aid to her HD facility however, HD 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 February 2024 eMAR's revealed a check for ,d+[DATE] night, a 9 for [DATE] day shift and a x for [DATE] night, [DATE] day and night shift. A review of the [DATE] eMAR's revealed checks for day and night shifts except for [DATE] there was a 9 for day shift; [DATE] and [DATE] there was a 5 for day shift. A review of the progress notes for the above eMAR documentation revealed the following progress notes: -[DATE] 11:14 eMAR - Medication Administration Note Note Text: Hearing aid to (bilateral) ears ON in AM and OFF in PM Red for right ear and Blue for left ear. every day and night shift for hearing loss -[DATE] 10:30 eMAR - Medication Administration Note Note Text: RESIDENT HAS SURGERY -[DATE] 11:50 eMar - Medication Administration Note Note Text: Hearing aid to (bilateral) ears ON in AM and OFF in PM Red for right ear and Blue for left ear. every day and night shift for hearing loss. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the progress notes for [DATE] did not reveal any additional documentation regarding the HA. A review of [DATE] eMAR's revealed checks for day and night shifts for the entire month. A review of the progress notes for [DATE] did not reveal any documentation regarding the HA. A review of the [DATE] eMAR's revealed checks for day and night shifts except for the [DATE] there was a 5 for the day shift. A review of the progress notes for the above eMAR documentation revealed a note: [DATE] 12:32 eMar - Medication Administration Note, Note Text: Refused meds after x3 attempts. Further review did not reveal any additional documentation regarding the hearing aid. A review of the [DATE] eMAR's revealed checks for day and night shifts except for [DATE] there was a 9 for day shift, [DATE] was blank for day shift, [DATE] & [DATE] there was a 9 for day shifts. A review of the progress notes for the above eMAR documentation revealed the following notes: -[DATE] 11:43 eMar - Medication Administration Note Note Text: Hearing aid to (bilateral) ears ON in AM and OFF in PM Red for right ear and Blue for left ear. every day and night shift for hearing loss no hearing aids, awaiting insurance approval -[DATE] 13:25 eMar - Medication Administration Note Note Text: Hearing aid to (bilateral) ears ON in AM and OFF in PM Red for right ear and Blue for left ear. every day and night shift for hearing loss no hearing aids. Further review did not reveal any additional documentation regarding the HA. On [DATE] at 11:09 AM, the surveyor interviewed the UC who stated she was aware of the missing left HA for Resident #46. The UC stated the facility tried to find the HA but they were unable to find it. She further stated she called the hearing aide company and left voice messages, but no one was returned the call. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:11 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated she was aware the left HA was missing. She stated the resident's family and the doctor were made aware at the time. The LPN/UM stated that the insurance company had been called. The LPN/UM reviewed the eMAR in the presence of the surveyor who verified the active PO dated [DATE]: Hearing aid to (bilateral) ears ON in AM and OFF in PM Red for right ear and Blue for left ear. every day and night shift for hearing loss. She stated, I would have my nurse put in a progress note if something was not done according to the order. The LPN/UM showed the surveyor the [DATE] progress note regarding the missing HA. She was unable to find additional progress notes regarding the HA at that time. The LPN/UM verified that a check symbol for the HA PO on the eMARs indicated that both hearing were signed as being administered and removed. On [DATE] at 11:31 AM, the surveyor interviewed Resident #46s assigned Registered Nurse (RN) who stated the resident had 2 HA's but one was lost and we tried to call the ENT (ear, nose, and throat physician). She stated the HA had been missing for 2 or 3 months. She verified if a PO was signed it means it was completed as ordered. The RN reviewed the eMAR in the presence of the surveyor. She acknowledged that she had signed that both HA 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 RN was unable to find any progress notes that she had made regarding the hearing aid at that time. She acknowledged that the doctor should have been called to change the PO. The surveyor asked the RN what's the purpose of accurate documentation was, she stated, to put correct information for what is going on with the patient. On [DATE] at 11:58 AM, the surveyor interviewed the facility's Director of Nursing (DON) who stated she was aware of Resident #46's missing HA. She stated the Assistant Director of Nursing (ADON) was looking into it the day it happened but she was unaware that it was still missing. The DON reviewed the electronic medical records in the presence of the surveyor who verified active PO for both the hearing aids. She reviewed the eMARs for March, April, May and June. She acknowledged that the HA's PO for both right and left ear 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 DON 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 administrator should have been made aware that the HA had not been replaced. On [DATE] at 01:12 PM, during a meeting with the survey team, the Regional Registered Nurse (RRN), the Director of Nursing (DON), the Regional Infection Preventionist (RIP), and the Licensed Nursing Home Administrator (LNHA), the surveyor presented the above concerns. The LNHA stated, this is not acceptable to check you are doing it and your not. The regional IP stated, staff was expected to follow standards of practice for documentation. A review of the facility's policy titled, Use of 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	37791 b-1.) On [DATE] at 10:00 AM, the surveyor observed Resident #101 who was alert and oriented and was in bed watching television. The resident was verbally responsive and had no issues 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, Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), Acute Kidney Failure (a condition in which the kidneys suddenly can't filter waste from the blood, Ogilvie syndrome (is an acute dilation of the colon in the absence of any mechanical obstruction in severely ill patients), and Hypertension (a condition in which the force of the blood against the artery walls is too high). A review of the quarterly Minimum Data Set (qMDS) assessment, a tool used to facilitate management of care, dated [DATE], indicated the facility assessed the resident's cognition using a BIMS test. Resident #101 scored a 9 out of 15, which indicated the resident was moderately impaired cognition. A review of the [DATE] 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 4th floor nursing unit revealed no Practitioner Orders for Life-Sustaining Treatment (POLST) (a written medical order from physician, nurse practitioner or physician assistant that helps give people with serious illnesses more control over their own care by specifying the types of medical treatment they want to receive during serious illness) or any readily available documentation indication the resident's code status. On [DATE] 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 code status. LPN #1 stated that she will need to verify the resident's code status. LPN #1 further stated that if the resident's does not have any listed code status, the resident will be considered a full code (full support which includes cardiopulmonary resuscitation (CPR), if the patient has no heartbeat). On [DATE] at 10:45 AM, the surveyor interviewed the 4th floor Registered Nurse (RN#1) who acknowledged that Resident #101 had no POLST. RN #1 also stated that a POLST was only required if the resident had a Do Not Resuscitate (DNR) and Do Not Intubate (DNI) code status. All the other residents with no POLST in the medical chart were considered as full code status. On [DATE] at 10:50 AM, the surveyor interviewed the 4th floor Licensed Practical Nurse/Unit Manager (LPN/UM) who acknowledged that there were no code status indicated in Resident #101's medical chart. On [DATE] at 1:10 PM, the surveyor discussed the above concerns with the administration team which included the LNHA, DON, RRN and the RIP. There was no additional information provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled Resident's Rights Regarding Treatment and Advanced Directives that was undated and was provided by the DON 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 [DATE] at 10:35 AM, the surveyor observed Resident #45 in bed watching television. The resident was alert and was verbally responsive and had no issues with care. The surveyor reviewed the hybrid medical record of Resident #45 which revealed the following: According to the AR, Resident #45 had diagnoses that included but were not limited to, Type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), adjustment disorder with mixed Anxiety and Depressed mood (a condition that combines symptoms of both adjustment disorder with anxiety and adjustment disorder with depressed mood), and Hypertension (a condition in which the force of the blood against the artery walls is too high). A review of the qMDS assessment, a tool used to facilitate management of care, dated [DATE], indicated the facility assessed the resident's cognition using a BIMS test. Resident #45 scored a 11 out of 15, which indicated the resident was moderately impaired cognition. A review of the [DATE] physician's OSR revealed a PO dated [DATE] for Clonazepam oral tablet 0.5 mg give 1 tablet via G-tube (gastrostomy tube) every 8 hours as needed for anxiety/agitation for 2 weeks. A review of the [DATE] eMAR revealed a PO dated [DATE] for Clonazepam oral tablet 0.5 mg give 1 tablet via G-tube every 8 hours as needed for anxiety/agitation for 2 weeks. Further review of the eMAR revealed that a nurse signed indicating that the above medication was administered on [DATE] at 1935 (7:35 PM). A review of the facility progress notes dated [DATE] at 15:57 (3:57 PM) revealed a Health Status Note which documented the following received patient sitting at the nursing station ready for Endoscopy appt (appointment) at [hospital redacted]; patient is alert and verbally responsive with no apparent distress. NPO (nothing by mouth) status maintained as ordered and morning meds (medications) withheld. At 10:02 am, patient left facility via stretcher with transport and nursing staff in stable condition. At 2:10 pm, patient returned to facility, alert and stable. PEG tube(Percutaneous endoscopic gastrostomy is an endoscopic medical procedure in which a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) removed; site checked, dressing intact, no excessive bleeding noted with less than 25% saturation. Good appetite noted post tray set up. Staff will continue to monitor patient for further care. On [DATE] at 1:10 PM, the surveyor discussed the above concerns with the administration team which included the LNHA, DON, RRN and the RIP. On [DATE] at 8:50 AM, the surveyor interviewed the 4th floor LPN/UM who stated that Resident #45's G-tube was removed on [DATE]. The LPN/UM further stated that the PO dated [DATE] for Clonazepam had the incorrect route (via G-tube) and the PO should have been verified by a nurse. There was no additional information provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Medication Administration that was undated and was provided by the DON that revealed the following: 10. Review MAR to identify medication to be administered. 33106 b-2.) On [DATE] 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 unspecified mood disorder, Diabetes Mellitus (DM) and Dysphasia (swallowing difficulty). The qMDS, an assessment tool that facilitates a resident's care, dated [DATE] indicated that the resident had severe cognitive deficits. A review of the progress notes (PN) documented by the facility's Social Worker, dated [DATE] at 13:05 (01:05 PM), indicated that Resident #146 had a full code status. The surveyor reviewed the nursing PN dated [DATE] at 09:07, which revealed that Resident #124 had a cardiac arrest and the staff performed CPR. The PN also indicated that 911 emergency number was called who then pronounced Resident #124 deceased . The surveyor reviewed the physician OSR which did not include a PO for the resident's code status. On [DATE] at 10:12 AM, the surveyor interviewed the facility's Director of Social Services (DSW) who stated that Resident #146 was a ward of the state (who is under the legal custody of a state or a subdivision of the state) and was considered an automatic full code status. The DSW further explained that Resident #146 had a legal guardian from the state who was making the decisions on the resident's behalf. The DSW reviewed the residents medical 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 full code status. The DSW stated that the only documentation for the resident's a full code status was included the social service progress notes. On [DATE] at 09:20 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) on the third floor who explained the process regarding identifying a resident's code status. The LPN stated that if a resident coded (generally refers to cardiac arrest, in such a case, urgent life-saving measures were indicated), the nurse would immediately check the resident's profile section on the EMR to determine if the resident was a full code or if the resident was a DNR. The LPN stated that a PO would not be required for a code status. The LPN reviewed the resident's profile in the presence of the surveyor and confirmed that the code status was not documented on the resident's profile in the EMR. The LPN further confirmed that there was no PO for a code status, however there was a documentation in the PN from the DSW that the resident was a full code secondary to being a ward of the state. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 09:35 AM. the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) on the 3rd floor who explained the process of obtaining a code status for a resident. The LPN/UM 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 code status. The LPN/UM stated that a PO was required for a resident's code status and must be documented on the resident's physical chart and on the resident's profile in EMR. The LPN/UM reviewed Resident #146's EMR with the surveyor and confirmed that there was no code status PO for Resident #146 nor was the code status documented on the resident's profile of the EMR. The LPN/UM explained that when a resident was a ward of the state, the resident was automatically considered a full code. The LPN/UM further stated that it would be important for the staff to obtain a PO for a resident's code status and must be documented on the resident's profile because time was of the essence when determining if the resident required CPR or not in the event of an emergency. The LPN/UM added that staff would not have the time to read all the PN to determine a resident's code status, but that if the code status was readily visible in the resident's profile or in the PO where it could be seen right away in an emergency. On [DATE] at 10:44 AM, the surveyor interviewed the DON who explained that a resident's code status should be documented in the resident's profile in the EMR. The DON also stated that a PO was required for a code status. There was no further information provided. A review of the facility's policy titled, Resident Rights Regarding Treatment and Advanced Directives dated , d+[DATE] 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. NJAC 8:,d+[DATE].2 (b); 29.2(d)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 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 significant weight changes (a weight loss or gain of 5% in 30 days and/or 10% in 180 days) 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 observed Resident #131 in bed. When interviewed, Resident #131 was noted alert and responsive. Resident stated they had weight loss 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 [DATE] with diagnoses that included but were not limited to Atrial Fibrillation, Parkinson's Disease, Schizoaffective Disorder, and Hypothyroidism. A review of the Quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care), dated 4/6/24, reflected that Resident #131 had a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete the interview. The MDS further reflected Resident #131 had a significant weight loss that was not a prescribed weight-loss 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 weight record in the EMR, the weights documented were as follows: 3/12/2024: 255.0 pounds (Lbs.) 3/21/2024: 253.9 Lbs. 3/25/2024: 239.2 Lbs. 3/25/2024: 239.2 Lbs. 4/2/2024: 237.9 Lbs. A review of the Registered Dietitian (RD) progress notes (PN), dated 3/12/24 documented that Resident #131 had a significant weight loss of 14.7 lb./5.8% in 30 days. Further review revealed there were no monthly physician's PN. The surveyor interviewed the 2nd 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. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 gained weight 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 [DATE] with diagnoses that included but were not limited to Heart Failure, Cerebrovascular Disease, Cognitive Communication Deficit, and Dysphagia. A review of the Q/MDS, dated [DATE], reflected that Resident #95 had a BIMS score of 00, indicating severe cognitive impairment. On 6/27/24 at 9:59 AM, the surveyor reviewed Resident #95's EMR and PMR chart. The surveyor reviewed the weight record in the EMR, the weights documented were as follows: 3/27/2023: 129.0 Lbs. 5/10/2023: 129.9 Lbs. 7/26/2023: 132.2 Lbs. 8/9/2023: 133.0 Lbs. 9/14/2023: 159.2 Lbs. 9/25/2023: 159.0 Lbs. A review of the RD PN dated, 9/20/23, documented that Resident #95 had a significant weight gain of 26.2 lb. /19.7% 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 weight gain, 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 Director of Nursing (DON), Regional Infection Preventionist (RIP) and Licensed Nursing Home Administrator (LNHA), all agreed the PP's need to address any significant weight changes in their monthly PN. On 6/28/24 at 12:00 PM, the DON 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 conditions that may be contributing to the weight loss. (continued on next page)

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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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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 1:12 PM, the survey team met with the LNHA, DON, RIP and Regional Clinical Nurse (RCN). The DON stated the PP's need to address any significant weight changes 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 weight gain was addressed in their monthly PN. NJAC 8:39-23.2 (b)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 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 alert and responsive. 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 [DATE] with diagnoses that included but were not limited to Atrial Fibrillation, Parkinson's Disease, Schizoaffective Disorder, and Hypothyroidism. A review of the Quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care), dated 4/6/24, reflected that Resident #131 had a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was unable to complete 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 no monthly physician's PN. The surveyor interviewed the 2nd Floor 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 Director of Nursing (DON), who stated that the MD was required to have monthly PN in the electronic or paper chart but was unable to explain why the MD had not written their monthly physician PN. On 6/28/24 at 1:12 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Regional Clinical Nurse (RCN), and Regional Infection Preventionist (RIP). The DON and RCN 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 LNHA, DON, RCN, and RIP for an exit meeting. Facility staff made no further comments. 46889 2. On 06/25/24, at 10:45 AM, the surveyor observed Resident #7 in bed awake, alert, and oriented, able to answer the surveyor's inquiry. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Multiple Sclerosis (disease of the brain and spinal cord). The Annual MDS, dated [DATE], indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored 14 out of 15, which indicates an intact cognition. 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 December 2023, January 2024, February 2024, March 2024, April 2024, May 2024, and June 2024. Furthermore, there were no physician PN in February 2024 and April 2024. 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 December 2023 through June 2024 were not reviewed and signed. Additionally, there were no physician PN for February 2024 and April 2024. The MD stated he was in the facility but the staff did not tell him to sign the monthly PO. The MD 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, alert with eyes open and was able to 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 Type 2 Diabetes Mellitus (high-level sugar in the blood). The QMDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 15 out of 15, which indicated that the resident had intact cognition. 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 December 2023, January 2024, February 2024, March 2024, April 2024, May 2024, and June 2024. On 7/01/24 at 09:46 AM, the LPN/UM stated that the MD was at the facility but didn't know why the MD missed to review and sign the PO. The UM/LPN from the 3rd floor stated she was unaware that the MD must sign the monthly PO. On 7/01/24 at 10:35 AM, the surveyor interviewed the MD over the phone regarding the above concern. The MD stated that he usually signed his monthly PO on the paper medical chart. The MD was informed that the monthly PO from December 2023 through June 2024 were not signed and the MD could not provide further information. On 7/01/24 at 10:41 AM, the surveyor team met with the LNHA, DON, RCN, and RIP to discuss the above concern. The DON stated that the unit clerk (UC) was in charge of having the MD review and sign the monthly PO's. If the UC were not in the building, the UC would call the MD to sign the monthly PO. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the the facility's policy dated 9/2023 provided by the DON 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)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48964 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 Unit Manager (UM) who stated that they check the contents of the trays against the meal tickets. The Unit Manager stated that Resident #4's lunch tray was correct. On second check, the UM stated that the milk was incorrect and that she 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 Type 2 Diabetes Mellitus (high blood glucose levels) and Bipolar Disorder (a mental disorder that causes unusual shift in a person's mood, energy, activity levels and concentration.) A review of the order summary included a physician order for a CCD/NAS (carbohydrate-controlled diet/No Added Salt) diet regular texture, thin consistency, large 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 13, indicating intact cognition. 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. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 to the resident. On 06/28/24 01:26 PM, the surveyor met with the facility's Licensed Nursing Home Administrator, Director of Nursing, Regional Clinical Nurse and Regional Infection Preventionist to discuss the above concerns. There was no further information provided. NJAC 8:39-17.4(a)1, 27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 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 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 Food Service Director (FSD) 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. FSD 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. FSD 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 FSD 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. FSD could not state when they had been opened. On 7/1/24 at 10:40 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Clinical Nurse (RCN), and Regional Infection Preventionist (RIT). The surveyor reviewed the kitchen inspections concerns. On 7/1/24 at 11:00 AM, the LNHA 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/2/24 at 10:13 AM, the survey team met with the LNHA, DON, RCN, and RIT. There was no additional information provided. NJAC 8:39-17.2(g)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37791 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: 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 Anemia (a condition in which blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body), recurrent Depressive Disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), and adjustment disorder with mixed Anxiety and Depressed mood (a condition that combines symptom of both adjustment disorder with anxiety and adjustment disorder with depressed mood). A review of the Quarterly Minimum Data Set (Q/MDS), an assessment tool used to facilitate the management of care, dated 06/19/24, reflected that the resident's cognitive skills for daily decision-making score were a 3 (three) which indicated that Resident #121's cognition was severely impaired. The Q/MDS further indicated that the resident was on Hospice. A review of the June 2024 Order Summary Report revealed a physician's order dated 03/12/24 for Hospice to evaluate and treat. A review of Resident #121's hospice care binder (HCB)which contained all the hospice care documentation for the resident, that was provided by the 4th floor Unit Clerk (UC), revealed a form titled, Hospice Visit Description Log (HVDL) and indicated it was last signed on 4/23/24. The HCB also included an interdisciplinary care plan and admission orders with initial plan of care. Further review of the HCB revealed no hospice nursing PN for June 2024. The last hospice nursing PN that was found was dated 03/13/24. There were no further nursing PN found in the hybrid medical record or in the HCB for Resident #121. On 6/28/24 at 9:30 AM, the surveyor interviewed the 4th floor Licensed Practical Nurse/Unit manager (LPN/UM) who stated that Resident #121 was under hospice care and a hospice aide would visit the resident daily. The LPN/UM further stated that the hospice nurse would visit the resident weekly and any notes from the visit must be placed in the HCB. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 11:30 AM, the surveyor interviewed the Hospice Registered Nurse/ Patient Care Coordinator (RN/PCC) who explained the operation and the process of care of the hospice company. The RN/PCC stated that the aide visits will depend on the resident's care plan and whoever would visit the resident from the hospice company would need to fill out the HVDL form that must be dated with description of care. The RN/HVDL further stated that a hospice 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 RN/PCC that the last hospice nursing PN found in the resident's medical record was a supplemental interdisciplinary note dated on 4/20/24 and the last entry in the form HVDL was on 4/23/24, the RN/PCC stated that the copy of the nursing PN were at the hospice company and there was no copy left at HCB 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 Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), Regional Clinical Nurse, and Regional Infection Preventionist. No additional information provided. A review of the facility's Coordination of Hospice Services policy that was undated and provided by the DON 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. 44605 2. On 6/25/24 at 11:37, surveyor observed Resident #95 in bed. The surveyor was unable to interview the resident. The surveyor spoke with resident's family via phone. The resident's family stated they have not spoken to the Physician (MD) about Resident #95's care. The surveyor reviewed the AR for Resident #95. The resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to Heart Failure, Cerebrovascular Disease, Cognitive Communication Deficit, and Dysphagia. A review of the Q/MDS, dated [DATE], reflected that Resident #95 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. 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 2nd Floor Unit 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 MD 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 MD 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 DON, RIP and LNHA. All agreed on the importance for staff to be able to read the physician's PN. The DON, RIP and LNHA were not able to read the physician's PN for Resident #95. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/24 at 1:12 PM, the survey team met with the LNHA, DON, RIP and Regional Clinical Nurse (RCN). The DON 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. 46889 3. On 6/25/24 at 10:27 AM, the surveyor observed Resident #77 sitting in bed, alert and awake, able to answer 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 Type 2 Diabetes Mellitus (high-level sugar in the blood). The Q/MDS, dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 15 out of 15, which indicated that the resident had an intact cognition. A review of the paper copy of the handwritten physician PN from December 2023 through June 2024 showed that they were all illegible. On 6/28/24, at 11:35 AM, the surveyors met with the LNHA and DON who both could not read all the monthly physician's PN. On 7/01/24 at 10:35 AM, the surveyor interviewed the MD over the phone. The MD 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 LNHA, DON, RIP, RCN 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 9/2023 did not specify about the physician's illegible handwriting. NJAC 8:39-35.2 (d)(5)