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	12/23/2025

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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews, and review of facility policies, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the dumpster and surrounding area free of garbage and debris. This deficient practice was observed and evidenced by the following:On 12/17/25 at 9:30 AM, the surveyor in the presence of the toured the Food Service Director (FSD) toured the kitchen and dumpster area and found the following:There was garbage debris that included shower chairs, hospital bed frames, a dresser, wooden pallets and cardboard boxes all observed on the outside of dumpster. The FSD stated the maintenance department should have cleaned the dumpster area.On 12/18/25 at 11:35 AM, the Director of Operations (DO) provided the surveyor with a facility policy titled, Dumpster/Garbage Area with a revision date of 9/2025. The procedure section of the policy revealed, 3. All waste storage areas and containers must be maintained in a clean and sanitary condition to prevent fire, health, or safety hazards and avoid attracting pests.On 12/22/25 at 1:16 PM, the surveyor met with the DO, Director of Nursing (DON), Licensed Nursing Home Administer (LNHA), Administrator in Training (AIT), and Regional Registered Nurse (RRN) to review concerns found during the survey. The DO stated the garbage area concerns will immediately be addressed.On 12/23/25 at 11:15 AM the surveyor met with DO, DON, LNHA, AIT and RRN for the exit conference; no further pertinent information was provided.NJAC 8:39-19.7

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, it was determined that the facility failed to provide a homelike environment in resident rooms. The deficient practice was observed on 2 of 3 units during initial tour.The deficient practice was evidenced by the following: On 12/17/25 at 10:42 AM, the surveyor toured the 2nd floor nursing unit and observed the following rooms: 1. room [ROOM NUMBER], there was a hole in the wall, and the walls were stained a brownish color, and the two privacy curtains stained. 2. room [ROOM NUMBER] observed damaged flooring tile and a damaged bathroom door. 3. In the hallway leading to the low-side rooms (rooms 200-216), the water fountain had been removed, and the wall was discolored and in need of repair. On 12/19/25 at 12:25 PM, two surveyors and the Maintenance Director toured the 2nd- and 3rd-floor nursing units and observed the following. 4. room [ROOM NUMBER] had a hole in the wall. 5. room [ROOM NUMBER]'s closet was in need of repair; the top part of the AC/Heater was missing. 6. room [ROOM NUMBER] and a hole in the wall, the closet needed repair, and the paneling on the sink was peeling. 7. room [ROOM NUMBER]'s two privacy curtains were stained with a brownish substance as well as the above-mentioned concerns 8. room [ROOM NUMBER]'s bathroom ceiling tile was stained, the toilet seat was discolored, the bathtub was stained and discolored, as well as the above-mentioned concerns. 9. room [ROOM NUMBER]'s wall was damaged behind the bed, and the wallpaper was peeling. 10. room [ROOM NUMBER]'s floor molding was peeling and in need of repair. 11. room [ROOM NUMBER]'s toilet seat was soiled and discolored, the bathroom ceiling tiles were stained, and the bathtub was stained, discolored and heavily soiled. On 12/18/25 at 11:27 AM, the surveyor interviewed the Director of Operations (DO), who stated the facility had received approval for interior renovations in November 2025 for all nursing units and the lobby. The DO provided the surveyor with the renovation schedule and a paid invoice for new bed headboards, dressers, and overbed tables. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/19/25 at 12:15 PM, the surveyor showed the above housekeeping concerns to the Director of Housekeeping (DHK). The DHK acknowledged the above housekeeping concerns and confirmed that this did not provide the residents with a clean, homelike environment. On 12/22/25 at 2:09 PM, the survey team met with the Licensed Nursing Home Administrator(LNHA), Director of Nursing (DON), and regional administration to discuss the above observations and concerns. A review of the facility's policy, Clean/Homelike Environment dated as reviewed 9/2025, reflected that residents are provided with a safe, clean, comfortable, homelike environment and encouraged to use their personal belongings to the extent possible. NJAC 8:39-4.1(a)11. 31.4 (a), (b), (c), (f)

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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 - Some	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** Based on observation, interview, and record review, it was determined that the facility failed to have readily accessible physician progress notes (PPN). This deficient practice was identified for 14 of 14 residents reviewed, (Resident #3, #17, #45, #55, #74, #83, #85, #105, #116 #122, #128, 132#, #135, and #137) and was evidenced by the following: 1. On 12/19/25 at 11:01 AM, the surveyor observed Resident #3 in the 2nd floor dayroom watching television. The resident stated, they do not recall seeing their primary physician (PP#1).A review of Resident #3 Face sheet (FS) (an admission summary) was admitted to the facility with diagnoses that included but were not limited to altered mental status (a change in mental function), pneumonia (an infection in the lungs), anemia (a blood disorder that happens when you don't have enough red blood cells).On 12/19/25 at 11:30 AM, the surveyor reviewed the Hybrid Medical Record (HMR), (combination of the physical and electronic chart) which did not reflect any PPN (process that involved assessing a patient's current vital signs, laboratory values, changes in condition, medical history and recommending care). A review of the quarterly Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 11/26/25, revealed that the resident had a score of 8 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated moderate cognitive impairment. 2. On 12/19/25 at 11:03 AM, the surveyor observed Resident #85 in the 2nd floor dayroom watching television. The resident stated, they do not recall seeing their PP#1 recently.A review of Resident #85 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to dementia (decline in cognitive function) and hyperlipidemia (an excess of lipids or fats in your blood).On 12/19/25 at 11:31 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the annual MDS, with an ARD of 9/24/25, revealed that the resident had a score of 5 out of 15 on the BIMS, which indicated severe cognitive impairment. 3. On 12/19/25 at 11:05 AM, the surveyor observed Resident #105 in the 2nd floor dayroom watching television. The resident stated, they do not recall seeing their PP#1 recently.A review of Resident #105 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to hyperlipidemia, thyroid disorder (conditions that affect thyroid functions), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest).On 12/19/25 at 11:33 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the quarterly MDS, with an ARD of 9/23/25, revealed that the resident had a score of 5 out of 15 on the BIMS, which indicated severe cognitive impairment. 4. On 12/19/25 at 11:10 AM, the surveyor observed Resident #128 in their room, in bed with their eyes closed.A review of Resident #128 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to anxiety (mental health conditions that cause fear, dread and other symptoms), hypertension (high blood pressure) and chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs).On 12/19/25 at 11:31 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the annual MDS, with an ARD of 9/24/25, revealed that the resident had a score of 5 out of 15 on the BIMS, which indicated severe cognitive impairment. 5. On 12/19/25 at 11:12 AM, the surveyor observed Resident #136 in the activities room. The resident stated they do not recall the last time they saw the PP#1.A review of Resident #136 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to bipolar disease (a mental health condition that causes extreme mood swings), depression, and muscle weakness (muscle injury or fatigue).On 12/19/25 at 11:33 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the quarterly MDS, with an ARD of 10/31/25, revealed that the resident had a score of 6 out of 15 on the BIMS, which indicated severe cognitive impairment. 6. On 12/19/25 at 11:15 AM, the surveyor observed Resident #83 in their room, in bed with their eyes closed.A review of Resident #83 Face sheet FS was admitted to the facility with (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses that included but were not limited to sepsis (a life-threatening organ dysfunction caused by a dysregulated host response to an infection), type 2 diabetes mellitus (a condition when the body cannot use insulin correctly and sugar builds up in the blood), and dementia .On 12/19/25 at 11:36 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the quarterly MDS, with an ARD of 10/13/25, revealed that the resident had a score of 3 out of 15 on the BIMS, which indicated severe cognitive impairment. 7. On 12/19/25 at 11:17 AM, the surveyor observed Resident #132 in the 4th floor dayroom. Resident #132 was unable to be interviewed by the surveyor due to confusionA review of Resident #132 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to anxiety, cerebral infarction (pathologic process that results in an area of necrotic tissue in the brain), and dementia.On 12/19/25 at 11:37 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the quarterly MDS, with an ARD of 9/22/25, revealed that the resident had a score of 6 out of 15 on the BIMS, which indicated severe cognitive impairment. 8. On 12/19/25 at 11:19 AM, the surveyor observed Resident #137 in the 4th floor dayroom. Resident #137 stated they do not remember if the PP#1 assessed them this month.A review of Resident #137 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to hypertension and depression.On 12/19/25 at 11:38 AM, the surveyor reviewed the HMR, which did not reflect any PPN. A review of the quarterly MDS, with an ARD of 9/10/25, revealed that the resident had a score of 6 out of 15 on the BIMS, which indicated severe cognitive impairment. 9. On 12/19/25 at 11:20 AM, the surveyor observed Resident #132 in the 4th floor dayroom. Resident #132 stated they saw the PP#1 earlier this month.A review of Resident #132 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to Parkinson's disease (movement disorder of the nervous system), anxiety and bipolar disorder.On 12/19/25 at 11:38 AM, the surveyor reviewed the HMR, which, did not reflect any PPN. A review of the quarterly MDS, with an ARD of 9/8/25, revealed that the resident had a score of 14 out of 15 on the BIMS, which indicated intact cognition. 10. On 12/19/25 at 11:22 AM, the surveyor observed Resident #17 in their room watching television. Resident #17 stated they saw the PP#1 earlier this month.A review of Resident #17 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to cerebral palsy (a brain disorder affecting body movement and muscle coordination), multiple sclerosis (s an autoimmune condition that affects your brain and spinal cord (central nervous system), and type 2 diabetes mellitus.On 12/19/25 at 11:39 AM, the surveyor reviewed the HMR, which, did not reflect any PPN. A review of the annual MDS, with an ARD of 10/12/25, revealed that the resident had a score of 14 out of 15 on the BIMS, which indicated intact cognition. 11. On 12/19/25 at 11:24 AM, the surveyor observed Resident #45 in their room watching television. Resident #45 stated they are not sure when they saw PP#1 last.A review of Resident #45 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to cerebral infarction, type 2 diabetes mellitus, muscle weakness.On 12/19/25 at 11:40 AM, the surveyor reviewed the HMR, which, did not reflect any PPN. A review of the annual MDS, with an ARD of 11/11/25, revealed that the resident had a score of 5 out of 15 on the BIMS, which indicated severe cognitive impairment. 12. On 12/19/25 at 11:26 AM, the surveyor observed Resident #55 in their room watching television. Resident #55 unable to state when last seen by to PP#1 due to cognitive impairment.A review of Resident #55 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to cerebral infarction, dementia, and aphasia (a condition that inhibits the ability to speak).On 12/19/25 at 11:41 AM, the surveyor reviewed the HMR, which, did not reflect any PPN. A review of the quarterly MDS, with an ARD of 11/25/25, revealed that the resident had a score of 0 out of 15 on the BIMS, which indicated severe cognitive impairment.13. On 12/19/25 at 11:28 AM, the surveyor observed Resident #74 in the 3rd floor dayroom watching television. Resident #74 unable to recall when last seen by PP#1.A review of Resident #74 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to schizophrenia (mental health condition that affects how people think, feel and behave) and hypertension.On 12/19/25 at 11:42 AM, the surveyor reviewed the HMR, which, did not reflect any (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PPN. A review of the quarterly MDS, with an ARD of 10/21/25, revealed that the resident had a score of 13 out of 15 on the BIMS, which indicated cognition intact. 14. On 12/19/25 at 11:28 AM, the surveyor observed Resident #116 in their room in bed, with their eyes closed.A review of Resident #116 Face sheet FS was admitted to the facility with diagnoses that included but were not limited to Alzheimer's disease, anemia, and hypertension.On 12/19/25 at 11:43 AM, the surveyor reviewed the HMR, which, did not reflect any PPN. A review of the quarterly MDS, with an ARD of 10/20/25, revealed that the resident was unable to complete a BIMS due to cognitive impairment. On 12/19/25 at 11:46 AM, the surveyor interviewed [NAME] 2nd floor unit manager (LPN#1), who stated the PP#1 completes their notes in their own charting system, and the facility staff does not have access to those notes. LPN further revealed the PP#1 is supposed to send the progress notes so they can be uploaded into the into the electronic chart or printed into the physical chart.12/19/25 at 12:43 PM, the surveyor conducted a phone interview with PP#1 who stated they write their progress notes in their own system and the facility staff does not have access to their system. PP#1 acknowledged they are behind on uploading resident notes and that it is not best practice.12/19/25 12:50 PM, the surveyor interview with Director of Nursing (DON) and Director of Operations (DO), who stated PP#1 should be uploading notes in a timely fashion within 48 hours.On 12/19/25 at 1:05 PM, the DON provided the surveyor with a facility policy titled, Physician Documentation, with a reviewed date of 10/2025. The procedures section of the policy revealed, B. Progress notes.1. A progress note must be entered into the clinical record for each visit, fully disclosing the kind and extent of services provided and the medical necessity for those services.On 12/22/25 at 1:16 PM, the surveyor met with the DO, DON, Licensed Nursing Home Administer (LNHA), Administrator in Training (AIT), and Regional Registered Nurse (RRN) to review concerns found during the survey. The DO stated all PPN will be audited.On 12/23/25 at 11:15 AM the surveyor met with DO, DON, LNHA, AIT and RRN for the exit conference; no further pertinent information was provided. NJAC 8:39-35.2 (d)(5)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that the resident receiving enteral feedings received appropriate care and services to prevent complications of enteral feedings, specifically by having the enteral feeding pump running with the resident in a supine position (head of bed flat) not elevated to prevent aspiration ((accidentally inhaling food or liquid through the vocal cords into the lungs). This deficient practice was identified for 1 of 2 residents (Resident #9) reviewed for tube feeding and was evidenced by the following:On 12/18/25 at 10:35 AM, the surveyor knocked at the door and, with the Certified Nursing Assistant's (CNA's) permission, entered the room. The surveyor observed the CNA providing care to Resident #9, who was in bed, lying flat with an enteral feeding tube pump (FT; a tube surgically inserted into the stomach to provide food and nutrients), administering Glucerna1.5 (nutritional formula) at a rate of 80 milliliters (mL) per hour. The surveyor reviewed the medical record for Resident #9. A review of the admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; acute respiratory failure with hypoxia (a severe medical condition where the lungs can't get enough oxygen into the blood), tracheostomy tube (a device inserted into a surgically created opening in the neck into the windpipe to help with breathing) and a gastrostomy tube (FT). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 10/4/25, indicated that the resident's cognitive skills for daily decision-making were severely impaired. A further review of Section K for Nutritional Status reflected that the resident received 51% or more of their nutrition through an enteral feeding tube. A review of the Physician Order Summary Report dated as of 12/22/25, included the following physician's orders (PO): A PO dated 8/18/25, to provide 300ml of free water flushes four times a day for a total of 1200 ml from water flushes. A PO dated 3/20/25, for Enteral feeding, Glucerna 1.5 @ 80 mL per hour; up at 4:00 PM, infused until total volume (TV) reaches 1300 mL, providing 1950 kcal per day. A PO dated 8/18/25, to keep the head of the bed elevated at least 30-45 degrees when enteral feeding is running and 1-2 hours after the total volume is delivered, unless contraindicated. A PO dated 1/24/25 to keep the head of the bed elevated greater than 30 degrees every shift for aspiration precautions. A review of the comprehensive care plan included a focus area in which the resident received tube feedings related to dysphagia (difficulty swallowing). The goal of the care plan reflected that the resident was to remain free of side effects or complications related to tube feeding. The interventions included but were not limited to:; elevate the head of the bed 45 degrees during and for thirty minutes after tube feed. On 12/18/25 at 10:43 AM, during an interview with the surveyor, the CNA acknowledged that she should have notified the nurse before she put the resident flat in bed so that the nurse could stop the feeding to prevent the resident from aspirating. On 12/18/25 at 10:55 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) assigned to Resident #9's care, confirmed that the CNA should have informed her before she provided care so that the LPN could have stopped the feeding, as the resident was at risk for aspiration if the feeding was going while the resident was lying flat. The LPN further stated that the resident's head should always be elevated during the feeding. On 12/22/25 at 2:09 PM, the survey team met with the Licensed Nursing Home Administrator(LNHA), Director of Nursing (DON), and regional administration to discuss the above observations and concerns. The DON confirmed that the Resident's head of bed should have been elevated to 30-45 degrees while the TF was being administered to prevent aspiration. The DON further stated that the CNA should have notified the LPN before lowering the head of the bed so the nurse could have stopped the feeding. A review of the CNA competency: Care of the resident with a feeding tube reflected that the CNA was responsible for ensuring that the resident's head of bed is elevated at 30-45 degrees when the enteral feeding is being administered.Notifies the nurse before providing care so the nurse can stop the feeding before the care is performed. NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, record review and review of facility policy, it was determined that the facility failed to a.) follow a Physician's Order (PO) for an Oxygen (O2) dependent resident in accordance with professional standards of practice and b.) store nebulizer tubing in a clean and sanitary manner for 2 of 4 residents, (Resident #9 and #97), reviewed for respiratory care. The deficient practice was evidenced by the following: 1. On 12/17/25 at 11:22 AM, the surveyor observed Resident #97 in bed with their eyes closed. Resident #97 was observed receiving O2 via nasal cannula (NC) (medical device to provide supplemental oxygen therapy to people who have lower O2 levels) at 3.5 liters/minute (LPM). On 12/17/25 at 11:45 AM, the surveyor reviewed Resident #97's electronic medical record (e-MAR) which revealed the following: The surveyor reviewed the admission Record (an admission summary) which revealed that the resident had been admitted to the facility with diagnosis that included hypertension (high blood pressure, means the force of blood pushing against your artery walls is too high), heart failure (an impairment in the heart's ability to fill with and pump blood) and cerebral infarction (a medical condition that occurs when the blood flow to the brain is disrupted). A review of the quarterly Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 10/28/25, revealed that the resident had a score of 0 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated severe cognitive impairment. The MDS also reflected that the resident received continuous O2 therapy. A review of the December 2025 PO for Resident #97's included a PO dated 12/3/25, O2 Inhalation at 2 LPM via nasal cannula as every shift for Shortness of Breath, Maintain Peripheral Oxygen Saturation (SpO2) at or greater than 92% with O2 inhalation. On 12/18/25 at 10:14 AM, in the presence of the Licensed Practical Nurse (LPN #1), the surveyor observed Resident #97's O2 machine set at 3.5 LPM. LPN#1 stated Resident #97 is on continuous O2 and the PO is for 2 L/min, unable to state why the O2 was set at 3.5 LPM. On 12/18/25 at 11:35 AM, the Director of Operations (DO) provided the surveyor with a facility policy titled, Oxygen Administration, with a revised date of 10/2025. The procedure section of the policy revealed, 1. Upon receiving an order for oxygen from the resident's physician the nurse will place the order in point click care (pcc) to be carried out. On 12/22/25 at 1:16 PM, the surveyor met with the DO, Director of Nursing (DON), Licensed Nursing Home Administer (LNHA), Administrator in Training (AIT), and Regional Registered Nurse (RRN) to review concerns found during the survey. The DON stated all residents on oxygen will be reviewed and concerns will immediately be addressed. On 12/23/25 at 11:15 AM the surveyor met with DO, DON, LNHA, AIT and RRN for the exit conference; no further pertinent information was provided. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 12/18/25 at 10:35 AM, the surveyor observed Resident #9 in bed. The resident did not respond to the surveyor. Resident #9 was observed receiving O2 via a tracheostomy tube (a device inserted into a surgically created opening in the neck into the windpipe to help with breathing), delivered at 5 LPM and 28% via an EasyAir machine (a portable air compressor that supplies compressed air 24 hours a day). The surveyor observed a nebulizer machine (a medical device that turns liquid medicine into a fine mist, allowing it to be inhaled directly into the lungs) on the resident's bedside table with the nebulizer tubing on the floor. The surveyor reviewed the medical record for Resident #9. A review of the admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; acute respiratory failure with hypoxia (a severe medical condition where the lungs can't get enough oxygen into the blood), tracheostomy tube and a gastrostomy tube (a feeding tube placed through the abdomen directly into the stomach to deliver nutrition). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 10/4/25, indicated that the resident's cognitive skills for daily decision-making were severely impaired. A further review of Section O indicated Resident #9 received special respiratory treatments, which included oxygen therapy and tracheostomy care. A review of the Physician Order Summary Report dated as of 12/22/25, included the following physician's orders (PO): A PO dated 6/20/25 for Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg/3 ml) 0.083% (Albuterol Sulfate) 3 ml via trach four times a day for increased secretions (to be given with 10 ml mucomyst 20%). A PO dated 1/23/25 for Pulmicort Suspension 0.5 mg/2 ml 1 unit via trach every 12 hours for shortness of breath/wheeze. A PO dated 9/23/25 for humidified oxygen at 5 lpm, 28% via trach every shift for humidification. A review of the comprehensive care plan included a focus area that the resident had a tracheostomy size six cuffed with O2 settings @ 5 lpm with Fi02 28% via trach r/t impaired breathing mechanics, and a traumatic brain injury. The goal of the care plan was for the resident to have clear, equal breath sounds bilaterally. The interventions included but were not limited to: give humidified oxygen as prescribed. On 12/18/25 at 10:55 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) assigned to Resident #9's care confirmed that the nebulizer tubing should be stored in a plastic bag for infection control prevention. At that same time, the LPN removed the nebulizer tubing from the floor and discarded it. On 12/22/25 at 2:09 PM, the survey team met with the Licensed Nursing Home Administrator(LNHA), Director of Nursing (DON), and regional administration to discuss the above observations and concerns. The DON confirmed that the nebulizer tubing should have been stored in a plastic bag to prevent the transmission of infection. (continued on next page)

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	12/23/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Oxygen Tubing and Respiratory Products revised 10/2025 included .It is the policy and procedure of this facility that all oxygen tubing is single-use for a single resident, clean, properly stored, and dated to prevent the transmission of infection .All nebulizer tubing shall be dated, stored in a bag when not in use, and replaced every 7 days . NJAC 8:39-27.1(a)