STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT #: NJ00186030 CENSUS: 133 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Complaint #: NJ186030 Based on interviews, review of medical records, and review of pertinent documents, it was determined that the facility failed to a.) conduct a thorough investigation and b.) follow the facility policy "Incident/Accident Investigating and Reporting Policy and Procedure," after a resident [NJ Exec] on facility premises on [NJ Exec Order 26.4b1]. This deficient practice was identified for one of three residents (Resident 2) reviewed for accidents and was evidenced by the following:	F 689	1. How the corrective action will be accomplished for those residents found to be affected by this practice? [NJ Ex Order 26.4(D)] Resident #2. The Regional Nurse alongside the Director of Nursing conducted a new thorough investigation into the incident regarding Resident #2, following the facility policy carefully. The Director of Nursing reviewed the incident report, re-interviewed the resident, as well as staff involved. The Director of Nursing reviewed the Police report as a part of her	6/9/25

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

Electronically Signed | 06/09/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 According to the Admission Record, Resident #2 was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), and need for assistance with NJ Ex Order 26.4(b)(1). Review of Resident #2's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed that Resident #2 had a Brief Interview for Mental Status score of NJ Ex out of 15 which indicated that the resident's NJ Exec Order 26.4b1 was NJ Ex Order 26 The MDS revealed that Resident #2 used a NJ Exec Order 26 wheelchair for NJ Exec Order 26.4 The MDS revealed that Resident #2 required the assistance of NJ Ex Order 26.4(b) prior to or following NJ Ex Order 26.4(b)(1) . The MDS further revealed that Resident #2 had not had NJ Ex Order 26.4(b) since the prior assessment. Review of a NJ Ex Order 26.4(b)(1) Report dated NJ Ex Order 26.4(b)(, written by NJ Ex Order 26.4(b)(1)) #1 was conducted. The report revealed that NJ Ex C #1 contacted Resident #2 after she/he NJ Ex C and was NJ Ex Order 26.4 at another location. NJ Ex C #1 and NJ Ex Order 2 made several unsuccessful attempts to reach facility staff regarding Resident #2. NJ Ex C #1 then went to the facility with Resident #2 and went inside to speak with staff including the facility's U.S. FOIA (b) (6)). The report revealed that while NJ Ex C #1 was speaking to facility staff inside, another staff member informed them that Resident #2, "had NJ Ex Order 26.4(b)(1) [her/his NJ Ex Order 26.4(b)(1) while right outside of the Canterbury NJ Ex Order 26.4(b)(1) ." The report further	F 689	investigation. After review of those items, it was concluded by the Regional Nurse and the Director of Nursing that the outcome of the re-investigation was the same as the initial investigation. The interventions put in place remained and staff continued to monitor. There were NJ Ex Order 26.4(b)(1) on Resident #2 by the facility's failure to thoroughly investigate and follow the facility policy on investigating incidents and accidents. 2. How the Facility will identify other residents having the potential to be affected by the same deficient practice? (a) All residents have the potential to be affected by the facility's failure to thoroughly investigate and follow the facility's policy on investigating incidents and accidents. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur? (a) The U.S. FOIA (b) (6) was re-inserviced by the Regional Nurse on the Facility's policy for investigating incidents and accidents (b) All Nurses were re-inserviced by the Director of Nursing on the facility's policy for investigating incidents and accidents (c) The Director of Nursing or designee will audit all incidents and accidents to ensure they are thoroughly investigated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 revealed that Resident #2 was then transported to the hospital by ambulance. A telephone interview was conducted with NJ Exec #1 on 05/21/2025 at 6:18 P.M. NJ Exec #1 stated that on NJ Ex Order 26.4(b)(1) after returning to the facility with Resident #2, he went inside to speak with facility staff while Resident #2 remained just outside of the facility entrance. NJ Exec #1 stated that while discussing the incident with facility staff, including the U.S. FOIA (b) another staff member informed them that Resident #2 had NJ Ex Order 26.4(b)(1) at the facility's NJ Ex Order 26.4(b)(1) PO #1 further stated that the facility staff went down to the entrance to assist the resident and get her/him into an ambulance. Review of a progress note (PN) written by Registered Nurse (RN) #2 dated NJ Ex Order 26.4(b)(1) at 6:20 P.M. revealed that at 6:20 P.M., RN #2 was notified by the NJ Ex Order 26.4(b)(1) that Resident #2 was NJ Ex Order 26.4(b)(1) such as NJ Ex Order 26.4(b) and a NJ Ex Order 26.4(b)(1) , and NJ Exec Order 26.4 medical assistance. The PN revealed that the U.S. FOIA (b) was made aware and got an order to transport Resident #2 to the hospital for evaluation. The PN further revealed that the resident did not return from NJ Ex Order 26.4(b)(1) A telephone interview was conducted with RN #2 on 05/13/2025 at 5:17 P.M. RN #2 stated that Resident #2 was assigned to her on the 3:00 P.M. to 11:00 P.M. shift on NJ Ex Order 26.4(b)(1). RN#2 stated that Resident #2 informed her that she/he was going outside to get some fresh air at approximately 3:15 P.M. RN #2 stated that a few hours later the U.S. FOIA (b) informed her that Resident #2 had NJ Ex Order 26 RN #2 stated that ordinarily, if one	F 689	and following the company's policy, monthly x 3 and quarterly thereafter. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur; (e.g., what quality assurance program will be put into place?) (a) The Director of Nursing or designee will bring the results of the following audit to the members of the QAPI team to determin frequency of future audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

of her assigned residents [NJ Ex O] she would have completed the necessary follow up. RN #2 stated that in this case the facility's [U.S. FOIA (b)] informed her that she would complete the follow up for the incident involving Resident #2. RN #2 further stated that the information included in her [NJ Ex Order 26.4(b)(1)] 6:20 P.M. PN was provided to her by the facility's [U.S. FOIA (b)]

Review of the facility incident report dated [NJ Ex Order 26.4(b)(1)] revealed that Resident #2 returned to the facility at 6:45 A.M. after leaving a hospital emergency department NJ Exec Order 26.4b1. The facility incident report further revealed under "Resident Description"' That Resident #2 provided a statement that at 4:30 P.M. she/he [NJ Ex [redacted] outside the facility in the [NJ Ex Order 26.4(b)(1)]

A review of a handwritten statement signed by Resident #2 revealed that the resident wrote that he/she NJ Ex Order 26.4(b)(1) on [NJ Ex Order 26.4(b)(1)] at approximately 4:30 P.M., outside on [NJ Ex Order 26.4(b)(1)]. The resident wrote that they were [NJ Ex Order 26.4(b)(1)] [redacted] and NJ Ex Order 26.4(b)(1). The resident further wrote that she/he was transported to the hospital by ambulance at approximately 5:00 P.M.

An interview was conducted with Resident #2 on 05/08/2025 at 12:24 P.M. Resident #2 was observed sitting in her/his room in a wheelchair. The resident had [NJ Ex Order 26.4(b)(1)] approximately [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] above her/his [NJ Ex Order 26.4(b)(1)] which was surrounded [NJ Ex Order 26.4(b)(1)]. There was NJ Ex Order 26.4(b)(1) [redacted] to the resident's [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)] The resident had [NJ Ex Order 26.4(b)(1)] on the [NJ Ex Order 26.4(b)].

Resident #2 stated that on [NJ Ex Order 26.4(b)(1)] she/he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

signed out of the facility then went to [NJ Ex Order 26.4(b)(1)] to the facility. The resident stated that she/he [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] on the [NJ Ex Order 26.4(b)(1)] at around 4:00 P.M. on [NJ Ex Order 26.4(b)(1)] The resident stated that after [NJ Ex Order 26.4(b)(1)], facility staff came outside to assist her/him.

A follow up interview was conducted with Resident #2 on 05/08/2025 at 4:41 P.M. The resident confirmed that they [NJ Ex Order 26.4(b)(1)] just outside of the facility's [NJ Ex Order 26.4(b)(1)].

Review of the facility document with "[Resident #2] Incident Summary [NJ Exec Order 26.4b1]" at the top revealed under "Summary," that Resident #2 signed out of the facility and went to [NJ Ex Order 26.4(b)(1)]. While at [NJ Ex Order 26.4(b)(1)] the resident [NJ Ex Order 26.4(b)(1)] while [NJ Ex Order 26.4(b)(1)]. The facility was [NJ Ex Order 26.4(b)(1)] when [NJ Ex Order 26.4(b)(1)] came to the facility and spoke to the [U.S. FOIA (b)]. The facility document further revealed that Resident #2 was sent to the hospital for evaluation prior to ever coming into the facility from [NJ Ex Order 26.4(b)(1)]

An interview was conducted with Registered Nurse (RN) #1 on 05/08/2025 at 4:18 P.M. RN #1 stated that Resident #2 told him that she/he (Resident #2) [NJ Ex Order 26.4(b)(1)] of the facility's [NJ Ex Order 26.4(b)(1)]

An interview was conducted with the facility's [U.S. FOIA (b) (6)]) on 05/08/2025 at 5:14 P.M. The [U.S. FOIA (b) (6)] stated that when accidents or incidents occurred facility staff completed a report in PCC (the electronic medical record). The [U.S. FOIA (b) (6)] stated that the staff would not have completed employee statement forms because the incident involving Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) (stated that the facility's policy, "Incident/Accident Investigating and Reporting Policy and Procedure," would have been followed if something happened on the premises. A follow up telephone interview was conducted with the U.S. FOIA (b) (on 05/21/2025 at 3:04 P.M., The U.S. FOIA (b) (stated that no additional summary, statements, conclusions, or other documentation were available for the incident involving Resident #2 on NJ Ex Order 26.4(b)(1). The facility U.S. FOIA (b was not available for interview on 05/08/2025 or 05/21/25. Review of the facility policy titled, "INCIDENT/ACCIDENT INVESTIGATING AND REPORTING POLICY AND PROCEDURE" with an updated date of 6/2024, revealed, "POLICY: It is the policy of this facility to provide a system whereby residents' incidents/accidents are investigated, their causes identified when possible, and timely interventions are established to reduce the probability of repeated incidents." Under "PROCEDURE" the policy revealed, "1. It is the responsibility of the Licensed Nurse who first witnessed the incident/accident to initiate and complete the Incident/Accident Report in its entirety utilizing input from the staff present at the time of the incident/accident. [...] 5. All employees assigned to the resident involved in an incident/accident will fill out the Employee Statement form [...] 8. The Unit Manager will investigate, summarize and conclude all incidents/accidents." NJAC 8:39-27.1(b)	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315204	A. BUILDING _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	**398 POMPTON AVENUE CEDAR GROVE, NJ 07009**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315204		6/24/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 06/09/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/8/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO