STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING ______ B. WING ______	C 05/18/2023

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CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Standard Survey Census: 172 Sample Size: 35+3 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. Complaint # NJ 159024, NJ 160832, NJ 160866, NJ 161344, NJ 163108, NJ 164241	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		6/15/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/01/2023

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.

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to create a homelike environment during dining by not removing food from serving trays. The deficient practice was observed in the facility's main dining room and was evidenced by the following: 1. On 05/03/2023 at 12:06 PM, the surveyor observed the main dining room at the lunch meal. 8 residents were present at various tables. 8 of 8 residents were observed to be eating their lunch meal from a plastic tray.	F 584	F584 SS=D 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The staff assigned to the dining room on 5/3/2023 and 5/8/2023 were immediately educated to remove the meal set up from the plastic tray and place the items on top of a placemat on the table. To ensure a homelike environment is provided to the residents, all nursing,	

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F 584	Continued From page 2 2. On 05/08/2023 at 12:06 PM, the surveyor observed the main dining room at the lunch meal. 11 of 11 residents present in the dining room were observed eating their lunch meal from a plastic tray. The facility did not provide a policy or procedure for dining pertaining to not serving residents on trays in the dining room. N.J.A.C. 8:39-4.1(a)(12)	F 584	dietary, and activity staff were immediately reeducated to remove the meal set up from the plastic tray and place the items on top of a placemat on the table. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any resident has the potential to be affected by the deficient practice. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. To ensure a homelike environment is provided to the residents, all nursing, dietary, and activity staff were immediately reeducated to remove the meal set up from the plastic tray and place the items on top of a placemat on the table. The DON or Designee will conduct audits weekly x 4 then monthly x 3 to ensure residents eating in the dining room are provided a homelike environment by having their meals served on a placemat on the table 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or Designee will conduct audits weekly x 4 then monthly x 3 to ensure residents eating in the dining room are provided a homelike environment by having their meals served on a placemat	

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F 584	Continued From page 3	F 584	on the table. All audit findings will be brought to the monthly QAPI meeting to determine if further action is necessary X 3 months.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review and review of other facility documentation, it was determined that the facility failed to contain oxygen/nebulizer delivery systems in a manner to prevent the spread of infection for 1 of 6 residents (Resident #120) reviewed for respiratory care. This deficient practice was evidenced by the following: On 05/03/2023 at 09:59 AM, during the initial tour of the facility, the surveyor observed Resident #120 lying in bed while NJ Exec. Order 26:4.b.1 Resident #120 stated that he/she wore NJ Exec. Order 26:4.b.1 continuously. On 05/09/2023 at 08:40 AM, Resident #120 was observed sitting up in bed eating breakfast. The NJ Exec. Order 26:4.b.1 was in the top drawer of the opened bedside table. The NJ Exec. Orde was uncovered and exposed. NJ Exec. Order 26:4.b.1 was observed to	F 695	F695 SS=D 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. A new NJ Exec. Order 26:4.b.1 were immediately provided to resident #120. The NJ Exec. Order 26:4.b.1 attached to the NJ Exec. Order 26:4.b.1 was immediately discarded and replaced with NJ Exec. Order 26 4.b.1 All nursing staff were reeducated on proper storage of NJ Exec. Order 26:4.b.1 and NJ Exec. Order 26:4.b.1 when not in use. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	6/15/23

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F 695	Continued From page 4 be in a back pocket of the resident's wheelchair. The NJ Exec. Order 26:4.b.1 was hanging from the push handle and was exposed while not in use. On 05/09/2023 at 01:57 PM Resident #120 was observed seated in their wheelchair in their room. The NJ Exec. Order 26:4.b.1 was observed in the top drawer of the bedside table with the drawer open. The NJ Exec. Order 2 was not in use and was uncovered and exposed. On 05/10/2023 at 09:17 AM Resident #120 was observed in bed with NJ Exec. Order 26:4.b.1 . The NJ Exec. Order 26:4.b.1 was hanging from the bed and suspended above the floor. The NJ Exec. Orde was uncovered and exposed. According to the Admission Record, Resident #120 was admitted to the facility with diagnoses including but not limited to: NJ Exec. Order 26:4.b.1 A review of the quarterly Minimum Data Set Resident Assessment Instrument (MDS), an assessment tool, Resident #120 had a Brief Interview for Mental Status score of NJ Exec. /15, indicating NJ Exec. Order 26:4.b.1 . According to section G of the MDS Resident #120 required NJ Exec. Order 26:4.b.1 with most activities of daily living. Section I of the MDS revealed that Resident #120 had active diagnoses of NJ Exec. Order 26: . Section O of the MDS revealed that Resident #120 received NJ Exec. Order 26:4.b.1 .	F 695	A facility wide audit was conducted on all residents that receive oxygen/nebulizer treatments to ensure proper storage of nasal cannulas and nebulizer masks. All residents receiving oxygen via a nasal cannula and utilizing nebulizer masks had the potential to be affected. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. All nursing staff were reeducated on proper storage of oxygen tubing and nebulizer masks when not in use. Chart reviews will be performed on all new admissions to identify if oxygen tubing or nebulizer mask is utilized by the resident. The Director of Nursing or designee will conduct audits weekly x 4 then monthly x 3 on all residents receiving oxygen and nebulizer treatments to ensure proper storage of oxygen tubing and nebulizer masks. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON or designee will conduct audits weekly x 4 then monthly x 3 on all residents receiving oxygen and nebulizer treatments to ensure compliance with proper storage of oxygen tubing and nebulizer masks when not in use. All audit findings will be brought to the monthly QAPI meeting to determine if	

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F 695	Continued From page 5 A review of the Order Summary Report, dated 05/17/2023, revealed the following physician orders: NJ Exec. Order 26:4.b.1 : keep NJ Exec. Order 26:4.b.1 , order date 05/23/2022. NJ Exec. Order 26:4.b.1 every day and night shift for NJ Exec. Ord, order date 01/16/2022. NJ Exec. Order 26:4.b.1 rder date 07/20/2022. A review of Resident #120's comprehensive care plan revealed a care plan Focus of: I have alteration in NJ Exec. Order 26:4.b.1, and I am on NJ Exec. Order 26:4.b.1 . Interventions include: NJ Exec. Order 26:4.b.1 as ordered. According to the Medication Administration Record, dated 05/01/2023-05/31/2023, Resident #120 received NJ Exec. Order 26:4.b.1 on the following dates and times: 5/1/2023 up to 5/17/2023 at 0600, 1400, and 2200. According to the Treatment Administration Record, dated 5/1/2023-5/31/2023, Resident #120 had the following treatment completed for day and night 5/1/2023 up to 5/16/2023: NJ Exec. Order 26:4.b.1 when not in use. Labeled with name and room #. Change as needed every shift for NJ Exec. Order 26:4.b Start date 08/23/2022 1900.	F 695	further action is necessary X 3 months.	

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F 695	Continued From page 6 On 05/11/2023 at 09:48 AM, the surveyor observed Resident #120 lying in bed with NJ Exec. Order 26:4. . The NJ Exec. Order 26:4.b.1 was observed on the floor and under the over the bed table. The NJ Exec. Orde was not covered and was exposed and in contact with the floor. The surveyor asked the resident if he/she had had a NJ Exec. Order 26:4.b.1 this morning. Resident #120 responded that he/she had not had a NJ Exec. Order 26:4.b.1 today and that they last had received a NJ Exec. Order 26:4.b.1 yesterday. The surveyor interviewed the Licensed Practical Nurse (LPN #2) assigned to Resident #120 on this shift. LPN #2 confirmed that Resident #120 received the prescribed NJ Exec. Order 26:4.b.1 is delivered via NJ Exec. Order 26:4.b.1. On 05/17/23 at 07:39 AM, the surveyor had LPN #3 come to Resident #120's room. Resident #120 was observed sleeping with NJ Exec. Order 26:4.b.1 The NJ Exec. Order 26:4.b.1 was lying on the floor next to the bed with NJ Exec. Order face down on the floor surface. When shown to LPN #3, LPN #3 stated, "That should be NJ Exec. Order 26:4.b when it is not in use. The night shift must have forgotten to NJ Exec. Order. The plastic storage bag is on top of the bedside table." On 05/17/23 at 10:54 AM the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) assigned to the B-Unit where Resident #120 resided. The surveyor asked RN/UM #1 what the facility practice for respiratory equipment was when not in use. RN/UM #1 responded, "Bagged, dated. Cleaned." On 05/17/23 at 01:10 PM the surveyor asked the facility Director of Nursing (DON) what the facility practice was for nebulizer mask storage when not in use, The DON replied, "Should be bagged and labeled when not in use."	F 695		

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F 695	Continued From page 7 The surveyor reviewed the facility policy titled Oxygen Administration, undated. The following was revealed under the heading Policy Explanation and Compliance Guidelines: 5. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measure include: c. Keep delivery devices covered in plastic bag when not in use. N.J.A.C. 8:39-27.1(a)	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Complaint # NJ00160866 Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide pain management that met professional standards of practice related to pain management. Specifically, by giving pain medication outside of the window of administration. This deficient practice was identified for 1 of 1 resident investigated for pain. The deficient practice was evidenced by the following:	F 697	F697 SS=D 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The Physician for resident #108 was notified of dates and times that the scheduled NJ Exec. Order 26:4.b.1 was administered outside of scheduled times. No new orders were obtained. Resident # 108 was not negatively affected as identified through assessment.	6/15/23

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Continued From page 8

On 05/09/2023 at 12:12 PM, during an interview with the surveyor, Resident #108 said that medications are sometimes an hour or an hour and a half late. He/She has called the police about his/her medications being late.

A review of Resident #108's quarterly Minimum Data Set (MDS) an assessment tool dated 02/27/2023, revealed that Resident #108 received scheduled and NJ Exec. Order 26:4.b.1 . It further revealed that Resident #108 experienced NJ Exec. Ord almost constantly.

A review of Resident #108's electronic medical record (EMR) revealed a diagnosis of but not limited to NJ Exec. Order 26:4.b.1

A review of Resident #108's physician's orders located in the EMR revealed an order for NJ Exec. Order 26:4 given by mouth every NJ Exec. Order 26:4.b.1 .

A review of Resident #108's care plan located in the EMR revealed that Resident #108 is at risk for NJ Exec. Or related to a medical condition/diagnosis. The care plan further revealed an intervention to administer medication as ordered.

A review of the "Medication Administration Audit" for January 2023 revealed NJ Exec. Order 26:4.b.1 tablets were administered on the following dates and times:

01/04/2023 scheduled for 02:00 PM and given at

F 697

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

A facility wide audit was conducted on all residents that receive scheduled pain medications to ensure pain medications were administered as ordered. All residents receiving pain medications had the potential to be affected. No residents were negatively affected as identified through assessment.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

The Assistant Director of Nursing re-educated all licensed Nurses on pain management to include medication administration timing. Each Unit Manager will conduct audits weekly x 1 month then monthly x 3 months on all residents receiving scheduled pain medications and medication administration timing to ensure compliance. An audit tool was created to log findings and compliance.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

The Director of Nursing will conduct random audits weekly x 1 month then monthly x 3 months, on residents receiving scheduled pain medications and medication administration timing to ensure

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F 697	Continued From page 9 03:46 PM 01/06/2023 scheduled for 10:00 PM and at given 11:55 PM 01/07/2023 scheduled for 02:00 PM and given at 05:22 PM 01/07/2023 scheduled for 10:00 PM and given at 12:30 AM on 01/08/2023 01/12/2023 scheduled for 02:00 PM and given at 03:19 PM 01/14/2023 scheduled for 10:00 PM and given at 11:39 PM. 01/15/2023 scheduled for 02:00 PM and given at 04:50 PM 01/18/2023 scheduled for 10:00 PM and given at 12:02 AM on 1/19/2023 01/19/2023 scheduled for 02:00 PM and given at 03:48 PM 01/29/2023 scheduled for 02:00 PM and given at 04:12 PM 01/27/2023 scheduled for 10:00 PM and given at 05:11 AM on 01/28/2023 On 05/17/2023 at 09:30 AM, during an interview with the surveyor, Registered Nurse/Unit Manager #1 stated that the window of time for administering medications was an hour before and an hour after the scheduled time. She further confirmed that the above orders were given outside of the administration time after the surveyor showed her the administration times. On 05/17/2023 at 01:01 PM, during an interview with the surveyor, the Director of Nursing (DON) confirmed that the window of time for administering medications was an hour before and an hour after the scheduled time. When the surveyor asked whether a NJ Exec. Order 26:4.b.1 scheduled for 2:00 PM should be given at 5:22 PM, the DON replied, "No."	F 697	compliance. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary X 3 months. A QAPI on residents receiving pain medication and timing of pain medication was implemented.	

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F 697	Continued From page 10 A review of the facility policy titled, "Administering Medications" with a revision date of April, 2021, states under "Policy Interpretation and Implementation" number 4., "Medications are administered in accordance with prescriber orders, including any required time frame." The policy further revealed under number 7., "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders.)" NJAC 8:39-27.1(a)	F 697		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		6/15/23

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F 755	Continued From page 11 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) to maintain a detailed record of receipts and accurate reconciliation of controlled medications for 7 of 7 Drug Enforcement Administration (DEA) 222 forms (a form used for ordering controlled substances)and b.) failed to ensure that controlled drugs are reconciled in accordance with facility policy and professional nursing standards on 1 of 5 SHIFT to SHIFT CONTROLLED MEDICATION COUNT LOG (B Unit, Cart #1). This deficient practice was evidenced by the following: A.) On 05/11/2023 at 09:22 AM, Surveyor #1 requested all of the DEA 222 forms for the last six (6) months from the Assistant Director of Nursing (ADON). The ADON provided Surveyor #1 with seven (7) DEA 222 forms. Surveyor #1 reviewed the DEA 222 forms and found seven of seven forms were not completed and accurately documented as follows: 1. DEA 222 form #221418084 was written on 12/22//22 and contained an order for 1 package of 20 Oxycodone IR (Immediate release) 5 milligram (mg), 1 package of 20 Oxycodone IR 10	F 755	1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. A) DEA 222 form # 221418084 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number received and date received were added to part 5 of DEA form # 221418084. DEA 222 form # 221418085 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number received and date received were added to part 5 of DEA form # 221418085. DEA 222 form # 221418091 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number received and date received were added to part 5 of DEA form # 221418091. DEA 222 form # 221418086 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number	

F 755 Continued From page 12

mg, and 1 package of 10 Morphine Sulfate 10 mg/0.5ml (milliliter). The DEA 222 form was missing the number received and date received.

The printed instructions on the front of the DEA 222 form indicated Part 5: "To BE FILLED IN BY PURCHASER, number of packages received and date received."

2. DEA 222 form #221418085 was written on 1/17/2023 and contained an order for 1 package of 30 Oxycodone IR 10mg. The DEA 222 form was missing the number received and date received.

The printed instructions on the front of the DEA 222 form indicated Part 5: "To BE FILLED IN BY PURCHASER, number of packages received and date received."

3. DEA 222 form #221418091 was written on 1/26/23 and contained an order for 1 package of 20 Oxycodone IR 10mg and 1 package of 30 Oxycodone IR 5mg. The DEA 222 form was missing the number received and the date received.

The printed instructions on the front of the DEA 222 form indicated Part 5: "To BE FILLED IN BY PURCHASER, number of packages received and date received."

4. DEA 222 form #221418086 was written on 3/10/23 and contained an order for 1 package of 30 Oxycodone IR 5mg tab (tablet), 1 package of 30 Oxycodone IR 10mg tab, 1 package of 10 Morphine Sulfate 10mg/0.5ml, 1 package of 10 Fentanyl 25mcg (microgram)/hr (hour) Patch. The DEA 222 form was missing the number received

F 755

received and date received were added to part 5 of DEA form # 221418086.
DEA 222 form # 221418087 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number received and date received were added to part 5 of DEA form # 221418087.
DEA 222 form # 221418088 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number received and date received were added to part 5 of DEA form # 221418088.
DEA 222 form # 230310473 was reviewed in conjunction with its attached inventory sheet. The number received and date received were noted. The number received and date received were added to part 5 of DEA form # 230310473.
All prior DEA 222 forms have been reviewed and Part 5 updated to include number received and date received. No residents were negatively affected by the deficient practice.

B) LPN # 1 was immediately re-educated by the Director of Nursing on the proper procedure when reconciling controlled medications at the beginning and the end of the shift. Facility audited the shift-to-shift count for 5/11/2023 7a-7p and 7p-7a and the count was correct. No residents were negatively affected by the deficient practice.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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	315257	A. BUILDING ______ B. WING ______	C 05/18/2023

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F 755	Continued From page 13 and the date received. The printed instructions on the front of the DEA 222 form indicated Part 5: "To BE FILLED IN BY PURCHASER, number of packages received and date received." 5. DEA 222 form # 221418087 was written on 3/21/23 and contained an order for 1 package of 30 Oxycodone IR 15mg tab and 1 package of Fentanyl 25mcg/hr Patch. The DEA 222 form was missing the number received and the date received. The printed instructions on the front of the DEA 222 form indicated Part 5: "To BE FILLED IN BY PURCHASER, number of packages received and date received." 6. DEA 222 form #221418088 was written on 4/4/23 and contained an order for 1 package of 10 Hydrocodone/Acetaminophen 5mg/325mg and 1 package of 30 Fentanyl 25mcg/hr patch. The DEA 222 form was missing the number received and the date received. 7. DEA 222 form #230310473 was written on 5/4/22 {?23}and contained an order for 1 package of 20 Oxycodone IR 5mg tab, 1 package of 30 Oxycodone IR 10mg tab and 1 package of 30 Oxycodone IR 15mg. The DEA 222 form was missing the number received and the date received. The printed instructions on the front of the DEA 222 form indicated Part 5: "To BE FILLED IN BY PURCHASER, number of packages received and date received."	F 755	A) All residents have the potential to be affected by this deficient practice. Facility audited completed DEA 222 forms and Part 5 was updated to include number received and date received. No further deficient practice was identified. B) All residents have the potential to be affected by this deficient practice. Facility audited all shift-to-shift logs for proper reconciliation. No further deficient practice was identified. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. A) Director of Nursing and Assistant Director of Nursing educated on the completion of the DEA 222 forms to ensure the facility maintains a detailed record of receipts and reconciliation of controlled medications. The DON/Designee will conduct audits weekly x 1 month then monthly x 3 months on all DEA 222 forms and Part 5 completion with number of packages and date received to ensure compliance. B) All Licensed Nurses were educated on the proper procedure for completing the shift-to-shift controlled medication count sheets. The shift-to-shift controlled medication log will be reviewed daily and any/all issues will be addressed with the licensed nurse. The DON/Designee will conduct weekly audits X 1 month then monthly X 3 months to ensure compliance. An audit tool was created to log and ensure compliance.	

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F 755 Continued From page 14

On 05/11/2023 at 10:47 AM, Surveyor #1 requested copy of the back of the DEA 222 form from the ADON.

On 05/11/2023 at 11:00 AM, Surveyor #1 received a copy of the back of the DEA 222 form from ADON. The back of the DEA 222 form includes "Instructions for the DEA 222 form under part 5 Controlled Substance Receipts,
1. purchaser fills out this section on its copy of the original order form
2. Enter the number of packages received and date received for each line item.
3. purchaser must keeps its copy of each executed order form and all copies of unaccepted or defective forms and any attached statements or other related documents available for inspection for a period of 2 years."

A review of an undated facility policy titled Federal Regulations Regarding DEA Form 222, revealed under the Procedures for obtaining, executing and filing of DEA Form 222 are described described within this code.
2. Receiving C-II Controlled Substances (Part 5)
A. Verify that the quantities, packaging size and items received from the pharmacy match what is on the retained copy of the original 222 form.
B. Fill in the number of packages received, and the date received for each item.

During an interview with Surveyor #1 on 05/17/2023 at 07:37 AM, the ADON said I was not aware there were directions for completing the DEA 222 form until you asked for a copy. I then saw what you were looking at and I will be completing part 5 as well.

B.) On 05/11/2023 at 10:11 AM, the B-Wing

F 755

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.

A) The LNHA will conduct random audits weekly x 1 month then monthly x 3 months, on DEA 222 forms to ensure compliance on completing Part 5 with number of packages and date received. All audit and findings will be brought to the monthly QAPI meeting to determine if further action is necessary.
B) The Director of Nursing will conduct random audits weekly X 1 month then monthly X 3 months on the shift-to-shift controlled medication count sheets. All findings will be brought to the monthly QAPI meeting to determine if further action is needed.

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F 755	Continued From page 15 Medication Cart #1 was inspected by Surveyor #2 in the presence of Licensed Practical Nurse (LPN #1). A review of the SHIFT to SHIFT CONTROLLED MEDICATION COUNT LOG for the month of May revealed a signature in the 7P-7A (7PM-7AM) signature box for the off-going nurse. During an interview at the time of observation, LPN #1 replied "yes" when asked if the incoming and outgoing signatures noted on the controlled medication count log for May 11th, 7A-7P and 7P-7A were hers. When asked should the same incoming nurse sign both the incoming 7AM-7PM and off-going 7P-7A box at the start of the 7AM shift, LPN #1 replied, "Usually I don't, but I did today, because I still have to leave at some point." On the same date at 10:53 AM, during an interview with Surveyor #2,Registered Nurse/Unit Manager (RN/UM #1) was asked to describe the process for the narcotic count. RN/UM #1 stated it should be a double count with incoming and outgoing nurse, the incoming nurse signs the incoming signature box that he or she verified the narcotic count. During an interview with the Surveyor #2 on 05/17/2023 at 09:52 AM, the ADON replied, "absolutely not" when asked should the incoming nurse sign both incoming and outgoing at the same time. A review of a facility policy "Controlled Substances" revised date of April 2019 indicates, " ...12. At the End of Each Shift: a. Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off	F 755		

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F 755	Continued From page 16 duty determine the count together." N.J.A.C. 8:39-29.7(c)	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: NJ Complaint: #NJ00160866 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow the prescriber's orders and accepted professional standards and principles by administering medications past the required time frame. The deficient practice was identified for 1 of 1 resident reviewed for being free of significant med errors. The deficient practice was evidenced by the following: A review of Resident #108's quarterly Minimum Data Set (an assessment tool) dated 02/27/2023, revealed that Resident #108 had a brief interview of mental status score of NJ Exe which indicated he/she was NJ Exec. Order 26:4.b.1. A review of Resident #108's physician's orders revealed the following orders but not limited to Digoxin tablet 250mcg (micrograms, medication NJ Exec. Order 26:4.b.1 one time a day and to NJ Exec. Order 26:4.b.1 used to	F 760	F760 SS=D 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The Physician for resident #108 was notified of dates and times that the scheduled NJ Exec. Order 26:4.b.1 were administered past the required time frame as ordered. No new orders were obtained for resident # 108. Resident # 108 was not negatively affected as identified through assessment. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. A facility wide audit was conducted on all residents medication administration time frames to ensure medications were administered as ordered by the Physicians. All residents receiving medications have the potential to be	6/15/23

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F 760	Continued From page 17 NJ Exec. Order 26:4.b.1 On 05/10/2023 on 11:43 AM, during an interview with the surveyor, Resident #108 said that they have informed the facility about receiving late medications and the facility did nothing about it when the surveyor asked if he/she told anyone about getting medications late. A review of Resident #108's "Medication Administration Audit Report" for January 2023 revealed the following medications were administered past the required time frame as follows: On 01/03/2023: NJ Exec. Order 26:4.b.1 scheduled for 09:00 AM was given at 10:31 AM NJ Exec. Order 26:4 scheduled for 09:00 AM was given at 10:29 AM NJ Exec. Order 26:4.b.1 scheduled for 09:00 AM was given at 10:31 AM NJ Exec. Order 26:4.b.1 scheduled for 09:00 AM was given at 10:31 AM On 01/16/2023: NJ Exec. Order 26:4.b.1 scheduled for 03:00 PM was given at 05:18 PM	F 760	affected. No residents were negatively affected as identified through assessment. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. The Assistant Director of Nursing re-educated all licensed Nurses on the proper procedure for administering medications in the required time frames and documented appropriately. Each Unit Managers will conduct audits weekly x 1 month then monthly x 3 months on all residents receiving medications to ensure medications are administered in the appropriate time frames. An audit tool was created to log findings and compliance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing will conduct random audits weekly x 1 month then monthly x 3 months, on residents receiving medications are administered in the required time frames. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary X 3 months. A QAPI on residents receiving medications out of designated time frame was implemented.	

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F 760	Continued From page 18 01/18/2023 NJ Exec. Order 26:4.b.1 scheduled for 09:00 PM was given at 12:15 AM on 01/19/2023 01/19/2023: NJ Exec. Order 26:4.b. scheduled for 09:00 AM was given at 10:12 AM NJ Exec. Order 26:4 scheduled for 09:00 AM was given at 10:12 AM NJ Exec. Order 26 4.b.1 scheduled for 09:00 AM was given at 10:12 AM NJ Exec. Order 26:4.b.1 scheduled for 09:00 AM was given 10:12 AM 01/20/2023: NJ Exec. Order 26:4.b.1 scheduled for 03:00 PM was given 05:57 PM 01/21/2023 NJ Exec. Order 26:4.b.1 scheduled for 03:00 PM was given at 04:17 PM 01/22/2023: NJ Exec. Order 26:4.b.1 scheduled for 09:00 AM was given at 01:22 PM NJ Exec. Order 26:4.b scheduled for 09:00 AM was given at 01:22 PM NJ Exec. Order 26 4.b.1 scheduled for 09:00 AM was given at 11:57 AM NJ Exec. Order 26:4.b.1 scheduled for 09:00 AM was given at 01:21 PM 01/22/2023: NJ Exec. Order 26:4.b.1 scheduled for 09:00 PM was given at 10:17 AM and the 03:00 PM dose was given at 4:43 PM. 01/26/2023	F 760		

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F 760	Continued From page 19 NJ Exec. Order 26:4.b.1 scheduled for 03:00 PM was at given 05:41 PM. On 05/17/2023 at 01:01 PM, during an interview with the surveyor, the Director of Nursing (DON) replied, "Hour before and an hour after" when asked what the window of time for administering medications was. The DON further revealed that, "Depending on the medication in your body, you take a medication and it builds up a level in your system and you want to maintain that level, so you are controlled." A review of the facility policy titled, "Administering Medications" with a revision date of April, 2021, states under "Policy Interpretation and Implementation" number 4., "Medications are administered in accordance with prescriber orders, including any required time frame." The policy further revealed under number 7., "Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders.)" N.J.A.C.: 8.39-29.2 (d)	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		6/15/23

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F 761	Continued From page 20 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to store a biological (Tubersol INJ [injection], used to aid in the diagnosis of tuberculosis infection [TB]) in accordance with the manufacturer's instructions. This deficient practice was identified in 1 of 5 medication carts inspected. On 05/11/2023 at 10:11 AM, the B-Wing Medication Cart #1 was inspected, by the surveyor, in the presence of Licensed Practical Nurse (LPN #1). Upon opening the bottom right-hand drawer, the surveyor observed an unopened box of house stock Tubersol INJ (Injectable) 5/0.1 ML (Milliters) manufactured by [company name]. A label affixed to the outside of the box indicated "Refrigerate, Do Not Freeze," as well as an image of a refrigerator and the word "REFRIGERATE" written in bold letters next to the image. At the time of the observation, LPN #1 stated that	F 761	F761 SS=D 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The unopened box of House Stock Tubersol was immediately removed and discarded appropriately from the B-Wing Medication Cart #1. No residents were negatively affected. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. A facility wide audit was conducted on all medication carts to ensure that no further Tubersol or other medications were stored inappropriately. No further issues were identified. All residents had the potential to	

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F 761	Continued From page 21 she was unsure of how long the Tubersol had been in the drawer. On the same day at 10:53 AM, during an interview with the surveyor, the Registered Nurse/Unit Manager (RN/UM #1) replied, "in the fridge" when asked how Tubersol should be stored. In addition, RN/UM #1 replied "yes" when asked should the Tubersol be stored under a controlled temp that's monitored. On 05/17/2023 at 09:52 AM, during an interview with the surveyor, the Assistant Director of Nursing confirmed that Tubersol should be stored in the refrigerator. The facility was unable to provide a policy pertaining to the storage of Tubersol. A review of the Tubersol manufacturer package insert indicated, "Store at 2° to 8° C (35° to 46° F)." N.J.A.C. 8:39-29.4(h)	F 761	be affected. No residents were negatively affected. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. The Assistant Director of Nursing re-educated all licensed Nurses on the proper medication storage of Tubersol and other medications. The medication carts will be checked daily by each unit manager in Unit rounds to ensure compliance. Any/all issues will be addressed with the Licensed Nurse. The Unit Managers and Nursing Supervisors will conduct audits weekly x 1 month then monthly x 3 months on the medication carts to include proper storage of House Stock Tubersol and other medications. An audit tool was created to log findings and compliance. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing will conduct random audits weekly x 1 month then monthly x 3 months, on facility medication carts to ensure proper storage of House Stock Tubersol and other medications. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary X 3 months.	
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		6/15/23

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CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

(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 803	Continued From page 22 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide all the items that were on the menu. This deficient practice occurred during one lunch meal that was observed in the main dining room and was evidenced by the following: 1. On 05/09/2023 at 11:48 AM, during the lunch meal in the main dining room, the surveyor	F 803	F803 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Residents were notified of the changes to the dessert served on 6/9/2023. The monthly menu listed apple pie as the	

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	315257	A. BUILDING ______ B. WING ______	C 05/18/2023

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F 803 Continued From page 23

observed 12 residents were present in the dining room. According to the menu, residents were to receive a slice of apple pie at the lunch meal on 05/09/2023. The surveyor observed 12/12 residents in the main dining room receive strawberry ice cream for dessert at the lunch meal instead of apple pie. The surveyor interviewed resident #39 during the lunch meal observation. Resident #39 stated to the surveyor when he pointed out that they were provided strawberry ice cream instead of apple pie, "Sometimes we get a piece of cake that is pink and sometimes we get strawberry ice cream, but we never get strawberry shortcake." The surveyor then told the resident that the dessert for the lunch meal was apple pie on 05/09/2023. Strawberry shortcake was to be served on 05/10/2023 at the lunch meal.

2. On 05/09/2023 at 12:09 PM, the surveyor interviewed the facility Dietary Director (DD). The DD stated, "We don't have strawberry shortcake. I've been doing red velvet cake. I can't get strawberry filling." The surveyor asked the DD what the facility process was for menu substitutions. The DD replied, "I have to get the dietitian to sign the substitution log. I didn't do it before making the substitution. The menu comes from corporate, and I've sent plenty of emails about not getting strawberry filling to make the strawberry shortcake." The DD then printed out a blank menu substitution form in the dietary office in the presence of the surveyor. The DD then filled in a lunch substitution of strawberry ice cream for apple pie and stated, "All I have to do now is get the dietitian to sign it." The surveyor asked for a copy of the substitution form. The DD asked the surveyor if she should have the dietitian sign off on it first. The surveyor

F 803

dessert instead an alternative dessert was served. Residents were informed the facility will make every reasonable attempt notify the residents of changes to the menu. The facility offered to serve apple pie on 6/19/2023 and strawberry shortcake on 6/23/2023.
The alternative will be submitted to the dietician for approval. The food service director, dietary supervisors, and dietician were in serviced on procedures of having the dietician review and sign menu substitution before a substitute is provided to residents.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

An audit of the next 14 day meal menu was performed to identify items not available for service. The substitution was submitted to the dietician for approval and residents were notified of the changes. The food service director, dietary supervisor, and dietician were in serviced on the facility process for meal substitution and resident notification. The food service director or designee will audit the menu daily to ensure the facility process was followed. The administrator will be notified of deficient practices

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F 803	Continued From page 24 responded, "No." (Note that surveyor and DD both were mistaken in thinking strawberry shortcake was to be served at the lunch meal on 05/09/2023. Both agreed to the mistake and agreed that apple pie was to be served at the lunch meal on 05/09/2023 and strawberry short cake was to be served at the lunch meal on 05/10/2023.) Apple pie was not available at the lunch meal, as indicated on the menu on 05/09/2023. 3. On 05/10/2023 at 01:31 PM, the surveyor conducted an interview with the facility dietitian. The dietitian told the surveyor, "I signed off on the dietary director's menu substitutions today for the past couple of days." The surveyor asked if she (dietitian) approves the menu substitution prior to the DD making the change or after the substitution has already been made. The dietitian responded, "No, I just sign off on them when I get to it." The facility did not provide a policy or procedure for menu substitutions. N.J.A.C. 8:39-17,2(b)	F 803	immediately. The audit will be performed weekly x 4 then monthly x 3. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Administrator will report monthly audit findings to the QAPI committee to determine if further action is necessary x 3 months.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		6/15/23

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F 812	Continued From page 25 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 05/03/2023 from 08:32 to 09:04 AM, the surveyor, accompanied by the Dietary Director (DD), observed the following in the kitchen: 1. On an upper shelf under the refrigeration unit of the walk-in refrigerator, an opened box contained individual packets of Daisy Sour Cream. The packets had a use by date of "jan 2023." The DD removed the box of individual sour cream packets to the trash. 2. On a lower shelf of the walk-in refrigerator, a sheet pan contained a package of ground beef pulled from the freezer to defrost. The ground beef had a "pull date" of 4/27/23 and a use by date of 5/2/2023, a period of 6 days. The DD stated, "Its garbage, we should only go 5 days after pull from freezer."	F 812	F812 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The box containing expired individual packets of Daisy Sour Cream was immediately discarded. The ground beef with a pull date of 04/27/23 was immediately discarded. The facility reviewed the monthly menus from 1/2023-5/2023 and sour cream was not listed on the monthly menus. The Dietary Aide pushing the food cart immediately placed her hair under a hairnet. The Dietary Aide was in- serviced on the requirement of a hair net when working around food. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected.	

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F 812	Continued From page 26 On 5/09/2023 at 12:16 PM the surveyor observed a dietary aide (DA) exit the kitchen door pushing a food cart to be delivered for the lunch meal. The DA had her hair in lengthy braids. The DA was not wearing a hair net and her hair was exposed. On interview the DD agreed that the DA was not wearing a hair net, and her hair was exposed in the kitchen. A review of the facility policy titled Dining Services Policy and Procedure 2G: Standards for Dry Storage. The following was revealed under the heading INSTRUCTIONS: 7. Don't keep or use food beyond the expiration or "use by" dates. A review of the facility policy titled Dining Services Policy and Procedure 2F" FIFO (First in, First out), undated, revealed the following under the heading INSTRUCTIONS: 3. Individuals receiving goods will arrange them in dry storage, coolers, and freezers with new items behind old items to ensure that older items are used first. (First In, First Out inventory rotation). 4. The individuals who remove products from storage will use the older stock first. The following was revealed under the heading MONITORING: 1. A direct supervisor will monitor that all foodservice employees are adhering to the above stated employee policy during all hours of operation. N.J.A.C. 18;39-17.2(g)	F 812	A full inspection in the kitchen, kitchen refrigerator, kitchen freezer, and kitchen dry storeroom were conducted in search of any other expired products and or past the use/pull by date. No other expired past due items were found. An audit of the monthly menus from 1/2023-5/2023 was performed and sour cream was not listed on the monthly menus. All kitchen staff were audited for the use of hair nets and beard protecters. All kitchen staff were found to be incompliance. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. All dietary staff were in-serviced regarding food storage, expiration and use by dates, inventory rotation process, and requirement of utilizing hair/beard nets while in kitchen and in contact with resident food. The Assistant Administrator or Designee will audit for compliance with the pull by and use by dates and staff compliance with the use hair/beard net weekly x 4 then monthly x 3. Audit findings will be in QAPI meetings. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.	

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F 812	Continued From page 27	F 812	The Dietician or designee will conduct random audits weekly x 12 and then monthly. Audit findings will be reported in monthly QAPI meetings to determine if further action is necessary X 3 months.	
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide access to the call system while a resident was in bed. The deficient practice was identified for 1 of 1 resident (Resident #423) investigated under the Environment Task. On 05/03/2023 at 09:40 AM, during the initial tour of the facility, the surveyor observed Resident #423 asleep in bed. At that time, the surveyor observed the handheld call system on the floor adjacent to the bed. On 05/11/2023 at 09:56 AM, the surveyor observed Resident #423 awake in bed. At that time, the surveyor observed the handheld call system on the floor adjacent to the bed.	F 919	F919 SS=D 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The handheld call system for Resident #423 was immediately placed within reach. Resident #423 was not negatively affected. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. A facility wide audit was conducted on all residents to ensure that the handheld call system was placed within reach. No further issues were identified. All	6/15/23

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F 919	Continued From page 28 On the same date at 10:00 AM, during an interview with the surveyor, Resident #423 said the handheld call system is on the floor sometimes and makes it difficult to get care. He/She stated that he/she leaves the door open so the staff can hear him/her. A review of Resident #423's Care Plan located in the Electronic Medical Record, revealed that he/she is NJ Exec. Order 26:4.b.1. The Care Plan revealed an intervention to, "Place call bell within reach." On 05/17/2023 at 01:01 PM, during an interview with the surveyor, the Director of Nursing (DON) replied, "Within reach, on their bed if they are on their bed." when asked where should a handheld call system be placed within the resident's room. The DON confirmed that the handheld call system should not be on the floor and that staff should put it back if it is inadvertently placed on the floor. A review of the facility policy titled, "Call System, Resident" dated September 2022 revealed under "Policy Interpretation and Implementation" number 1., "Each resident is provided with a means to call staff directly for assistance from his/her bed..." N.J.A.C. § 8:39-31.8	F 919	residents have the potential to be affected by this practice. No residents were negatively affected. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. All staff were in-serviced to place the handheld call system within reach of the resident. Audits will be conducted weekly x 1 month then monthly x 3 months on the handheld call system to ensure compliance and the call bell is placed and secured within reach. The Administrator or designee will monitor daily for compliance during daily preventive rounds. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing or designee will conduct random audits weekly x 1 month then monthly X 3 months on the handheld call system to ensure the call bell is placed within reach. All findings will be brought to the monthly QAPI meeting to determine if further action is necessary X 3 months.	

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	060808	A. BUILDING: ______ B. WING ______	C 05/18/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00160866, NJ00164241 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 13 of 14-day shifts for weeks of 01/15/2023 and 01/22/2023, and 14 of 14-day shifts, and was deficient in total staff for residents on 3 of 14 evening shifts for the weeks of 04/16/2023 and 04/29/2023 reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	S560 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. The facility administrator together with the director of human resources reviewed the facilities hiring program. Facility rates and incentives were reviewed. Reviewed contracts and rates with staffing agencies. The facility reviewed the on-boarding process as well as options to expedite the hiring process. Employee recognition programs are in place, employee of the month and perfect attendance bonuses	6/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/23

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility for the weeks of 01/15/2023 and 01/22/2023, the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -01/15/23 had 16 CNAs for 180 residents on the day shift, required 22 CNAs. -01/16/23 had 18 CNAs for 180 residents on the day shift, required 22 CNAs. -01/17/23 had 20 CNAs for 179 residents on the day shift, required 22 CNAs. -01/18/23 had 20 CNAs for 178 residents	S 560	are available to facility staff. The facility has a sign on bonus, pays for schooling, employee referral program, and is scheduled to have an open house for recruitment on June 13,2023. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. • The staffing coordinator was re-in serviced on the required ratios. • Licensed nurses and CNAs were in-serviced regarding the facility call out policy. • Staff were in serviced regarding incentives to refer employees. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Human Services will audit the CNA ratios for all shifts, weekly for one month and then monthly for three months. Results of the audit will be shared with the monthly QAPI committee.	

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on the day shift, required 22 CNAs.
-01/19/23 had 17 CNAs for 178 residents on the day shift, required 22 CNAs.
-01/20/23 had 16 CNAs for 178 residents on the day shift, required 22 CNAs.
-01/21/23 had 17 CNAs for 178 residents on the day shift, required 22 CNAs.
-01/22/23 had 15 CNAs for 180 residents on the day shift, required 22 CNAs.
-01/23/23 had 19 CNAs for 180 residents on the day shift, required 22 CNAs.
-01/24/23 had 21 CNAs for 180 residents on the day shift, required 22 CNAs.
-01/25/23 had 20 CNAs for 180 residents on the day shift, required 22 CNAs.
-01/27/23 had 20 CNAs for 179 residents on the day shift, required 22 CNAs.
-01/28/23 had 17 CNAs for 178 residents on the day shift, required 22 CNAs.

As per the "Nursing Staffing Report" completed by the facility for the weeks of 04/16/2023 and 04/29/2023, the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below:

The facility was deficient in CNA staffing for residents on 14 of 14-day shifts and deficient in total staff for residents on 3 of 14 evening shifts as follows:

-04/16/23 had 8 CNAs for 170 residents on the day shift, required 21 CNAs.
-04/17/23 had 10 CNAs for 170 residents on the day shift, required 21 CNAs.
-04/18/23 had 16 CNAs for 170 residents on the day shift, required 21 CNAs.
-04/19/23 had 12 CNAs for 170 residents on the day shift, required 21 CNAs.

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CEDAR GROVE RESPIRATORY AND NURSING CENTE	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

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S 560	Continued From page 3 -04/20/23 had 15 CNAs for 174 residents on the day shift, required 22 CNAs. -04/21/23 had 13 CNAs for 171 residents on the day shift, required 21 CNAs. -04/21/23 had15 total staff for 171 residents on the evening shift, required 17 total staff. -04/22/23 had 15 CNAs for 171 residents on the day shift, required 21 CNAs. -04/23/23 had 11 CNAs for 169 residents on the day shift, required 21 CNAs. -04/23/23 had 16 total staff for 169 residents on the evening shift, required 17 total staff. -04/24/23 had 13 CNAs for 169 residents on the day shift, required 21 CNAs. -04/24/23 had 16 total staff for 169 residents on the evening shift, required 17 total staff. -04/25/23 had 13 CNAs for 169 residents on the day shift, required 21 CNAs. -04/26/23 had 11 CNAs for 169 residents on the day shift, required 21 CNAs. -04/27/23 had 9 CNAs for 172 residents on the day shift, required 21 CNAs. -04/28/23 had 9 CNAs for 171 residents on the day shift, required 21 CNAs. -04/29/23 had 11 CNAs for 171 residents on the day shift, required 21 CNAs. During an interview with the Staffing Coordinator (SC) on 05/11/2023 at 09:52 AM, the SC stated that it was her responsibility to staff the facility. The SC stated that there are times when they do not meet the staffing requirements. During an interview with a Certified Nursing Assistant (CNA #1) on 05/11/2023 at 09:05 AM, CNA #1 stated that there were 2 CNA's for the 60	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060808	A. BUILDING: ______ B. WING ______	C 05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTE	**1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094**

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S 560	Continued From page 4 residents on Unit C. The CNA added that they typically have no more than 3 CNA's during her shift for 60 residents. During an interview with the survey team on 05/17/2023 at 01:03 PM, the Director of Nursing (DON) stated that she knows the staffing ratio requirements for CNA's: on days 1:8, evenings1:10 and on nights 1:14. The DON added; "We are not meeting those requirements every day every shift." A review of the facility policy titled, "Staffing," with a revision date of August 2022, included, "Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratio's	S 560		
S2235	8:39-31.6(c) Mandatory Physical Environment (c) Fire regulations and procedures shall be posted in each unit and/or department. A written evacuation diagram that includes evacuation procedures and locations of fire exits, alarm boxes, and fire extinguishers shall be posted conspicuously on a wall in each resident care unit and/or department throughout the facility. This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of facility documentation on 05/09/2023 and 05/10/2023 in the presence of facility management, it was determined that the facility	S2235	S2235 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient	6/15/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2235	Continued From page 5 failed to: 1) Identify the fire alarm pull stations and locations of the fire extinguishers for 1 of 1 emergency evacuation diagrams posted in the facility and 2) Failed to post an emergency evacuation diagrams on 3 of 4 resident sleeping units. This deficient practice was evidenced by the following: On 05/09/2023 at 08:37 AM, during the survey entrance, a request was made to the facility Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms, smoke compartments and wings/ units in the facility. A review of the facility provided lay-out identified that there are the following wings in the facility: B- unit, C- unit, Sub-Acute unit and the Vent (Ventilator dependent) unit. Starting at 09:06 AM on 05/09/2023 and continued on 05/10/2023 in the presence of the DOM a tour of the building was conducted. Along the two day (05/09/2023 and 05/10/2023) tour of the facility, the surveyor observed one (1) emergency evacuation diagram posted in the corridor of the Vent unit. This emergency evacuation diagram failed to include the locations of the fire alarm pull stations and the fire extinguishers. The surveyor observed no evidence of emergency evacuation diagrams posted on the B unit, C unit and Sub-Acute unit. The facility failed to post an emergency evacuation diagrams specific to the 3 units.	S2235	practice. No residents have been affected by this practice. An emergency evacuation diagram was created for B unit, C unit, Subacute unit, and Vent unit. The diagram includes evacuation procedures, location of fire exits, fire alarm pull stations, and fire extinguishers. Specific diagrams were posted on B unit, C unit, Subacute unit, and Vent unit. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. The Director of Maintenance, maintenance staff, and all other staff have been in serviced on the requirements of maintaining proper evacuation diagrams to include evacuation procedures, location of fire exits, fire alarm pull stations, location of fire extinguishers, and for the diagrams to be posted on each resident care unit and/or throughout facility. The Maintenance Director inspected the facility and posted diagrams where necessary. A log called “evacuation diagram” was created to track the proper postings of emergency diagrams on all resident care units. The Maintenance Director or designee will audit and log monthly	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CEDAR GROVE RESPIRATORY AND NURSING CENTE	**1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094**

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S2235	Continued From page 6 NJAC 8:39 -31.6 (c).	S2235	ensuring proper evacuation diagrams are posted in all required areas. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315257	A. Building B. Wing	7/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

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 F0697 Reg. # 483.25(k) LSC	Correction Completed 06/15/2023	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	
5/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060808	A. Building B. Wing	7/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/15/2023	ID Prefix S2235 Reg. # 8:39-31.6(c) LSC	Correction Completed 06/15/2023	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
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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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/18/2023	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING **01** B. WING ___________	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/09/2023 and 05/10/2023 and Cedar Grove Respiratory and Nursing Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Cedar Grove Respiratory and Nursing Center is a Single-story, Type II Protected building that was built in January 1988. The facility is divided into 12 smoke zones. The facility has one 400 KW Diesel emergency generator.	K 000		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations on 05/09//2023 and 05/10/2023 it was determined that the facility failed to ensure continuous illumination for 2 of 19 designated exit discharges was provided and arranged so that the failure of any single lighting unit did not result in an illumination level of lass than 0.2 ft-candle in any designated area in accordance with NFPA 101 Life Safety Code	K 281	K281 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents have been affected by this	6/15/23

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/01/2023

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 DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 281	Continued From page 1 (2021 edition) Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4 This deficient practice was evidenced by the following: On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with nineteen (19) designated exit discharge (illuminated exit signs above doors) doors in the facility for Residents to use during an evacuation in the facility. Starting at approximately 09:06 AM on 05/09/2023 and continued on 05/10/2023, in the presence of the facility's DOM, a tour of the facility was conducted. During the two day building tour the surveyor observed the following, On 05/09/2023, 1) At approximately 11:20 AM, the surveyor observed outside the designated exit discharge door next to Resident room #C-113, had a single light bulb fixture. 2) At approximately 11:34 AM, the surveyor observed outside the designated exit discharge door #11, had a single light bulb fixture. The DOM confirmed the findings at the time of	K 281	practice. An additional light fixture with continuous lighting was installed providing two illuminated lamps outside the designated exit discharge door next to resident room # C-113. An additional light fixture with continuous lighting was installed providing two illuminated lamps outside the designated exit discharge door # 11. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. The Maintenance Director, maintenance staff, and all other staff were in-serviced on the regulation that all means of egress are to be provided with continuous lighting with two lamps. All designated discharge doors were inspected by the Director Of Maintenance and found to have two illuminated lamps outside the door. A log called exit illumination was created to track compliance of two lamp illumination at all exits. The Director of Maintenance or designee will observe and log compliance monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

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K 281	Continued From page 2 observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 01:22 PM. N.J.A.C. 8:39 -31.2 (e) NFPA 101 2012 -19.2.8	K 281	will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 05/09/2023 and 05/10/2023 in the presence of facility management, it was determined that the facility failed to: provide six (6) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants.	K 293	K293 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by this practice. Two continuously illuminated exit signs were installed in the small courtyard, one above each of the two designated exit access doors. The two designated exit access doors are clearly identified with the exit access route to reach an exit. Two continuously illuminated exit signs were installed in the large enclosed	6/15/23

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K 293 Continued From page 3

NFPA Life Safety Code 2012 7.10.5.2.1
Continuous Illumination.
Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2

Reference: New Jersey Uniform Construction Code 5:23:
International Building Code,
1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge."

2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."

On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

K 293

outside courtyard, one above each of the two designated exit access doors. The two designated exit access doors are clearly identified with the exit access route to reach an exit.
Two continuously illuminated exit signs were installed near the subacute nursing station. The two illuminated exit signs clearly identify the exit access route to reach an exit.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected by this practice.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

The Maintenance Director, maintenance staff, and all other facility staff were in serviced on the regulation of exit and directional signage related to continuous illuminated lighting systems. The Director of Maintenance inspected all of the facilities other paths of egress and found all to have visible illuminated exit signs visible per regulation. A log called “egress illumination” was created to track compliance. The Director of Maintenance or designee will observe and log findings and compliance monthly.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and

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K 293	Continued From page 4 A review of the facility provided lay-out identified the facility is a single-story building with two enclosed (surrounded by the building) center courtyards. Starting at approximately 09:06 AM on 05/09/2023 and continued on 05/10/2023 in the presence of the facility's DOM a tour of the facility was conducted. Along the two (2) day tour, the surveyor observed six (6) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 05/09/2023: 1) At approximately 10:44 AM, the surveyor observed in the "Small" enclosed outside courtyard that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. 2) At approximately 10:50 AM, the surveyor observed in the "Large" enclosed outside courtyard that the facility failed the have two (2) illuminated exit signs. One illuminated exit sign above each of the two (2) designated exit access doors that clearly identifies the exit access route to reach an exit. On 05/10/2023: 3) At approximately 10:46 AM, the surveyor observed in the Sub-Acute Nursing station area the facility failed to provide two illuminated exit signs that clearly identifies the exit access route to reach an exit.	K 293	will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 293	Continued From page 5 The DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 01:22 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		6/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING 01 B. WING	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

(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
K 324	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation on 05/09/2023, it was determined that the facility failed to maintain the range hood grease baffles in accordance with NFPA 101, 2012 Edition, section 19.3.2.5.1, 9.2.3 and NFPA 96, 2011 Edition. The evidence of this deficient practice includes the following, During the building tour on 05/09/2923 in the presence of the facility's Director of Maintenance (DOM) at approximately 09:40 AM an inspection inside the kitchen was performed. The surveyor observed two (2) grease baffle filters were missing metal pieces. This left an approximately 1" opening in each filter. This would allow fire and grease vapors to enter the range hoods exhaust system. The DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 1:22 PM. NFPA 101, NFPA 96. NJAC 8:39 -31.2 (e).	K 324	K324 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice. No residents have been affected by this practice. The two damaged grease baffles on top of the kitchen ranges were removed and were replaced with new sets of grease baffles ensuring full closure with no ability of fire or grease vapors to enter the range hoods exhaust system. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur. The Maintenance Director, maintenance department, Food Service Director, and dietary department staff were in-serviced on requirements of ventilation control and fire protection of commercial cooking. All other baffles above the kitchen range	

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	315257	A. BUILDING **01** B. WING ______	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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
K 324	Continued From page 7	K 324	were inspected by the Director Of Maintenance and found to be functioning properly. A log called “baffle protection” was created to track compliance of proper function of baffles. The Food Service or designee will observe and log findings and compliance monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Food Service Director will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor for compliance during daily rounds.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced	K 374		6/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING 01 B. WING ___	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

(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

K 374

Continued From page 8

by:
Based on observations and review of facility provided documentation on 05/09/2023 and 05/10/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 15 sets of corridor smoke barrier doors tested and was evidenced by the following:

Reference 1:
- 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch.

On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified the facility is a single-story building with twelve (12) smoke zones.

Along the two (2) day tour of the facility, the surveyor performed a closure test of seventeen (17) sets of double smoke doors in the corridors with the following results,

1) On 05/09/2023 at approximately 11:10 AM, during a closure test of the double smoke doors in the corridor next to Resident room #C-103 when the doors were release from the magnetic

K 374

K374
1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.

No resident has been affected by this practice.
An astragal molding was installed on the corridor smoke door next to resident room # C-103. When the smoke doors release and self-close into their frame, they leave no gap on the bottom edge ensuring no allowance of transfer of smoke, fire, or poisonous gases to pass from one compartment to another.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected by this practice.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

The Maintenance Director, maintenance staff, and all other facility staff were in serviced on the requirements of maintain proper smoke barriers. All facility corridor smoke doors were inspected by the Director of Maintenance and found to close without any gaps. A log called “smoke door barriers” was created to track the function of smoke doors. The Director of Maintenance or designee will

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING **01** B. WING ______	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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
K 374	Continued From page 9 hold open device and allowed to self close into their frame, the surveyor observed and measure a 1/2 inch wide by 8 inch high gap along the bottom meeting edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The DOM confirmed the finding at the time. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 1:22 PM. N.B. 8:39-31.1(c), 31.2(e)	K 374	observe and log findings and compliance monthly. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor compliance during daily rounds.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 05/09/2023 and 05/10/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 3 of	K 521	K521 1. How corrective actions will be accomplished for those residents found to have been affected by the deficient practice.	6/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315257	A. BUILDING **01** B. WING ______	**05/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	**1420 SOUTH BLACK HORSE PIKE** **WILLIAMSTOWN, NJ 08094**

(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

K 521

Continued From page 10

10 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A.

This deficient practice was evidenced by the following:

On 05/09/2023 (day one of survey) during the survey entrance at approximately 08:37 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility.

A review of the facility provided lay-out identified that the facility is a single-story building with 103 Resident sleeping rooms and various common areas.

Starting at approximately 09:06 AM on 05/09/2023 and continued on 05/10/2023 in the presence of the facility's DOM a tour of the facility was conducted.

Along the two (2) day tour the surveyor inspected ten (10) Resident sleeping rooms bathroom exhaust systems.

This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 3 of 10 resident bathrooms in the following locations:

On 05/09/2023,
1. At approximately 09:57 AM, inside Resident room #B-109 bathroom, when tested the exhaust system did not function properly.

K 521

No residents have been noted to be affected by this practice.

The facility HVAC vendor evaluated the exhaust system for this unit and noted that the motor needed to be replaced. A new motor was ordered and replaced on May 25, 2023. The exhaust system was tested and functioned properly. Resident bathrooms of room #B-109, room #B-116, room #B-102 were tested and are functioning properly.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents have the potential to be affected by this practice.

3. What measures will be put into place, or systemic changes made to ensure the deficient practice will not recur.

The Maintenance Director, maintenance staff, and all other staff have been in-serviced on the requirement of maintaining working ventilation and exhaust systems. All ventilation systems throughout the facility have been inspected by the Director of Maintenance and found to be functioning properly. The Director of Maintenance or designee will perform weekly inspections on B unit bathrooms numbers 109, 116, and 102 weekly for three months and monthly thereafter. A log called bathroom ventilation system was created to for these rooms to log findings. The

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	315257	A. BUILDING 01 B. WING ______	05/18/2023

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K 521	Continued From page 11 At that time, the surveyor informed the DOM that the exhaust system did not function properly. The DOM told the surveyor that he is aware that some of the bathroom exhaust systems are not working properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:03 AM, inside Resident room #B-116 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:41 AM, inside Resident room #B-102 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The DOM confirmed the findings at the time of observations. The surveyor informed the Administrator of the deficiency at the Life Safety Code exit conference on 05/10/2023 at approximately 1:22 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521	Maintenance Director will perform monthly inspections on all ventilation systems throughout the building for six months. A log called ventilation systems has been created to log findings. To ensure that all facility ventilation systems throughout the facility are functioning properly the Director of Maintenance or designee and Administrator has incorporated visual observation and monitoring of ventilation systems on daily preventive rounds. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Maintenance will report compliance monthly to QAPI committee and quarterly to QA committee for six months. The Administrator will observe and monitor compliance during daily rounds.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315257	A. Building 01 - MAIN BUILDING 01 B. Wing	7/6/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR GROVE RESPIRATORY AND NURSING CENTER	1420 SOUTH BLACK HORSE PIKE WILLIAMSTOWN, NJ 08094

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 Reg. # NFPA 101 LSC K0281	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 06/15/2023
ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 06/15/2023	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 06/15/2023	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	
5/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO