PRINTED: 11/23/2021 FORM APPROVED

New Jersey Department of Health

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					С	
		060808	B. WING		10/07	7/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
CEDAR G	ROVE RESPIRATORY A	ND NURSING CENTS	H BLACK HO	RSE PIKE		
OLDAN O	NOVE REDITION A	WILLIAMS	TOWN, NJ 08	094		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	CTION SHOULD BE O THE APPROPRIATE	
S 000	Initial Comments		S 000			
	C #: NJ148441,NJ144925, NJ143835, NJ146720, NJ145420, NJ148447, NJ145914, NJ144624, NJ143553 Census: 171 Sample Size: 9					
	The facility is not in c requirements of 42 C Long Term Care Faci complaint survey.	FR Part 483, Subpart B, for				
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		S 560			10/29/21
	by: Complaint #NJ 14844	41		All residents have the potential to be affected if minimum staffing levels are most. No residents were negatively.		
	documentation, it was failed to maintain the care staff to resident mandated by the Sta	nd review of pertinent facility is determined that the facility required minimum direct ratios for the day shift as te of New Jersey. This was a shifts for week one and 6 of two.		met. No residents were negatively affected. The facility staffing coordinator is collaborating with a recruitment agence assist the facility in hiring new staff, whas proven positive results in hiring arretention.	hich nd	
	Findings include:			All residents have the potential to b affected by a staffing shortage. No residents were negatively affected.	E	
	(NJDOH) memo, date with N.J.S.A. (New Je	ey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) um staffing requirements for		The facility staffing coordinator has been educated by the Director of Nurson the New Jersey Department of Heat	sing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

10/26/21

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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				7.1. 50.25.1.10.		c	
		060808		B. WING		1	7/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CEDAR G	ROVE RESPIRATORY AN	ID NURSING CENTI		H BLACK HO			
	OUR MAN DV OT		WILLIAMS	TOWN, NJ 080		. 1	
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S 560	Continued From page 1		S 560				
	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			Nurse Staffing Report and how to utilize and monitor the sheets on a daily bas Administration will determine if incenticare needed to ensure the facility is in compliance with the state requirement. 4. Administrator/Director of Nursing with monitor the staffing on a weekly basis	is. ives ts.		
	residents for the day shift.			ensure that minimum staffing levels at maintained. The results will be submi	re itted		
	fewer than half of all s CNAs, and each direct	ing shift, provided that r staff members shall be ct staff member shall be a CNA and shall perform			to our QAPI meeting monthly X 3 mor and determine if compliance is met.	nths	
		t shift, provided that eac per shall sign in to work					
	the facility for the wee 9/5/21 to 9/11/21, the	offing Report" completed eks of 4/4/21 to 4/10/21 a staffing to resident ratio minimum requirement or r the day shift as	and os				
	_	ent in CNA staffing for 7 or week 4/4/21 to 4/10/2					
	the day shift, required than 8 residents for each of the day shift, required 04/06/21 had 16 the day shift, required the day shift, required	CNAs for 160 residents 20 CNAs. CNAs for 160 residents	on on				

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		(X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE S COMPLI	
				7.: BOILBING: _			
		060808		B. WING		1	, 7/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRES					TE, ZIP CODE		
CEDAR	PROVE DESCRIBATORY AN	UD NUBEING CENTS	420 SOUTH	H BLACK HO	RSE PIKE		
CEDAR	ROVE RESPIRATORY AP	ND NORSING CENT!	VILLIAMST	OWN, NJ 080	094		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE	
S 560	Continued From page 2			S 560			
S 560	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		5 560				