STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. Survey Date: 05/11/21 Census: 93 Sample: 19 + 14 = 33	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		5/27/21

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

Electronically Signed | 05/24/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interviews and document review it was determined that the facility failed to consistently respond to issues and concerns presented during resident council meetings and resident questionnaires obtained from residents in lieu of a formalized resident council meeting. This deficient practice was evidenced by the following: 1. According to a facility summary of individual resident questionaire document dated 01/19/21, individual questionnaires were passed out to residents by activity staff. The document revealed under the discussion/ follow up section, under the dining services current comments "the food could come hotter". There was no documented response from the dietary department or any administrative staff regarding the concerns expressed by the residents.	F 565	1. An audit of food temperature logs was completed from December 2020 to April 2021 to ensure that all foods were served at the appropriate temperature. No abnormal findings were discovered, and the findings were shared with members of the resident council meeting held on 5/27/2021. An audit of the menus from the past two cycles were reviewed to determine the number of times chicken was served in relation to other protein sources i.e. beef, seafood, lamb, or pork. It was determined that seafood was the most frequently served entr¿e for the past cycle, and that there were no instances where chicken was served two meals in a row. The findings of this audit were shared with member of the resident council at the May	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 565	Continued From page 2 2. According to a summary of individual resident questionaire document dated 02/23/21, individual questionnaires were passed out to residents by activity staff. The document revealed under the discussion/ follow up section, under the dining services current comments "one resident commented they are tired of chicken and would like more seafood" and "the menu needs tremendous improvement including diversification and taste". There was no documented response from the dietary department or administrative staff regarding the concerns expressed by the residents. 3. According to a summary of individual resident questionaire document document dated 03/25/21, which revealed the discussion/ follow up for an in person resident council meeting. There was no documented response from the dietary department or administrative staff regarding the prior resident concerns. During the resident council meeting conducted by the surveyor on 05/06/21 at 1:00 PM three out of four residents stated "the food was cold" and "there was too much chicken and pasta on the menu". On 05/10/21 at 9:04 AM, the surveyor interviewed the acting manager (AM) of the activity department. The AM stated that questionnaires were completed with the residents in person until resident council meeting could resume. She stated the meeting minutes were then uploaded for the management team to address any concerns and the management team included the administrator (LHNA). On 05/10/21 at 10:47 AM the surveyor reviewed	F 565	2021 meeting. A review of the resident council meeting minutes from March 2021 were reviewed with the dining services team to address the concerns that were not resolved from the previous meeting. The concerns were reviewed with members of the resident council at the May 2021 meeting. DATE OF COMPLETION: 5/27/21 2. All residents have the potential to be affected by the deficient practice. 3. All members of the leadership team will be inserviced on the policy titled, Resident or Family Group Meetings, as well as the resolution process for any concerns raised from resident and/or family meetings. Members of the dining services, maintenance, programming, and nursing teams will be in attendance at the monthly resident council meetings if requested by members of the resident council. Any concerns brought forward at the resident council meeting will be recorded in the minutes, where they will be distributed to all of the departments. Concerns that were raised will require a written action plan to address the concerns, and will be submitted to Administration within two weeks of the conclusion of the meeting. The results of the plan will be presented to the resident council at the following meeting for resolution or modification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 565	Continued From page 3 the Resident or Family Group Meeting Policy, provided by the LHNA and dated 10/2020 . The policy revealed that if any concerns were conveyed in the resident group meeting, department heads responded to the group approved designated staff person within two weeks with a written action plan and action plans and minutes were submitted to the LHNA for signature. The surveyor interviewed the LHNA about the action plans for the concerns expressed by the residents. The LHNA stated that he could not provide any action plans for the resident concerns because it was more conversational than anything and there was no action plans. On 05/07/2 at 11:22 AM the surveyor interviewed the dietary general manager (GM) regarding receiving any resident food complaints since January 2021. He stated he could not recall if there were any concerns. On 05/10/21 at 11:12 AM the surveyor interviewed the GM regarding any feedback he had received regarding resident concerns from the resident council. He stated that he had not received resident council feedback since October 2020. He then provided the surveyor with a copy of an email with the subject resident council questionnaire feedback. The email revealed multiple residents stated there was too much chicken and the residents wanted more variety and choices. The email further revealed that multiple residents stated the food was cold at times. The surveyor inquired to the GM if he had completed an action plan related to the resident complaints. He stated no he did not as he was unaware that he needed to complete an action plan based on resident council feedback.	F 565	4. Any actions plans created as a result of resident council meetings will also be submitted to the QAPI committee for review and analysis, identification of trends, etc. with results reported to the committee for resolution or modification. Action plans will be reviewed monthly x3 months by the QAPI committee to ensure resolution has occurred.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 565	Continued From page 4	F 565		
F 698 SS=D	NJAC 8:39-4.1(a)(29) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive 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: Based on observation, interview, medical record review and review of other pertinent facility documentation it was determined that the facility failed to: a.) consistently and appropriately assess, monitor and document the care of [redacted] ite according to professional standards of practice and b.) create a resident centered care plan for the care of an [redacted] for [redacted] residents (Resident [redacted]) reviewed for [redacted]. This deficient practice was evidenced by the following: According the the Face Sheet for Resident # [redacted] the resident was admitted to the facility [redacted]. The comprehensive admission Minimum Data Set, an assessment tool, dated [redacted] Executive Order 26, 4.b. [redacted] Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse	F 698	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. Complete nursing assessment of [redacted] was immediately conducted on 5/10/21 by RN for [redacted], signs and symptoms of infection, bleeding, bruising, pain, redness, or swelling. Medical provider notified upon completion of assessment. b. Care plan updated to include frequency of monitoring and assessment areas of [redacted]. c. Resident was educated on monitoring [redacted] and the importance of reporting any changes immediately to nursing staff. d. All nursing staff was educated beginning on 5/10/21 on how to accurately assess an [redacted] 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. Any other residents with an [redacted]	5/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 698	Continued From page 5 Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On [redacted] at 09:07 AM, the surveyor attempted to interview Resident #[redacted] who was not in his/her room. The surveyor interviewed the primary Licensed Practical Nurse (LPN) at this time who stated the Resident #[redacted] was at the [redacted] Executive Order 26, 4.b. The LPN stated that Resident #[redacted] had a [redacted] Executive Order 26, 4.b. and that the Executive Order 26, 4.b. (A [redacted]) Executive Order 26, 4.b.	F 698	have the potential to be affected by the deficient practice. There are currently no other residents present with an [redacted]. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? a. All new nurses will be educated on how to accurately assess an [redacted] upon hire. b. Any resident with an [redacted] will have a comprehensive care plan in place regarding the frequency of monitoring and assessment areas of the fistula site. c. Any resident with an [redacted] will have an order present in the treatment administration record to document [redacted] assessment every shift. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. DON and/or designee will audit new hire orientation agenda for nurses to ensure AV fistula assessment education is provided monthly x6 months. b. DON and/or designee will audit charts and care plans of residents with AV fistulas upon admission ongoing. c. Upon admission of a resident with an AV fistula, DON and/or designee will audit the care plan and treatment administration record weekly x4 weeks, biweekly x4 weeks, and monthly x2 months. d. Results of these audits will be submitted to the Quality Assurance Process Improvement Committee monthly. The committee will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 698	Continued From page 6 Executive Order 26, 4.b.) daily which was documented in the nurse's notes. The LPN added that there were no physician orders to monitor the Executive Order 26, 4.b. because the facility had a new computer system and it was difficult to put these types of orders into the program. She stated that they used to write orders to monitor Executive Order 26, 4.b., but they don't do that anymore. She said they had this new computer program for the last 2 years. On Executive Order 26, 4.b. at 09:10 AM, the surveyor interviewed the Registered Nurse Clinical Manager (RNCM) for Executive Order 26, 4.b. who stated that when a Executive Order 2 resident was Executive Order 26, 4.b. the nurses were expected to check access site to make sure it was intact, and there were no signs or symptoms (S/S) of infection. She also stated that all Executive Order 2 were checked every shift Executive Order 26 The RNCM further stated that there was physician orders (PO) written for the Executive Order 2 schedule that included the time and days that the resident received Executive Order 26, 4.b. The RNCM was unsure if there a physician order was required to monitor the Executive Order 2 access site. In the presence of the surveyor, the RNCM reviewed the physicians orders and Treatment Administration Records (TAR) for Resident # Execu and stated there were no physicians orders for resident # Execu to receive Executive Order 26, 4.b. nor were there physician orders to monitor the Executive Order 2 access site. The RNCM added that the facility usually did not obtain physician orders to monitor the access site because it was a "nursing judgement".	F 698	findings and make recommendations as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 698	Continued From page 7	F 698		

On [redacted] at 12:21 PM, the surveyor interviewed the primary LPN who documented that she took Resident # [redacted] while the [redacted]. The LPN indicated that she made an error in documentation and that she did not take Resident [redacted] She stated that Resident [redacted] was [redacted] and would not allow anyone take his/her [redacted]. The LPN also added that the resident wore a [redacted] bracelet on the [redacted] blood draws for labs or for blood pressures.

On [redacted] at 08:30 AM, the surveyor interviewed Resident [redacted] who was observed in his/her room sitting in a wheelchair. Resident [redacted] was alert and oriented and answered all questions appropriately. The resident indicated that he/she had been at the facility for a couple of weeks and was [redacted] at the hospital. Resident [redacted] stated that the staff did not take blood pressures or draw blood for labs in the left arm.

The surveyor observed that the resident had an [redacted] that was covered with [redacted]. Resident [redacted] removed bandages from the [redacted] to show the surveyor. According to the resident, he/she had been on [redacted] since November 10, 2019. The surveyor also observed that Resident [redacted] was wearing a black bracelet on [redacted] which included the following information, [redacted] Additionally, the surveyor observed a [redacted] on the resident's [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 698	Continued From page 8 On 05/06/21 at 09:05 AM, the surveyor observed the primary Executive Order 26, 4.b. for [redacted]. The LPN palpated the vascular access site to feel for the thrill, however she did not auscultate the vascular access with a stethoscope to detect a bruit. On [redacted] at 11:40 AM, the surveyor interviewed the LPN who stated that on 05/06/21 at 09:05 AM when the surveyor was observing her assessing Resident [redacted] and she did not use a stethoscope to detect the bruit, the LPN admitted to the surveyor that she forgot to do it. The Physician Order Sheet dated May 2021 and April 2021 were reviewed and did not reflect orders for [redacted] access site care or monitoring and also did not include specific times and frequency that the [redacted] access site should be monitored. The Treatment Administration Record (TAR) did not reflect physician orders to monitor and care for dialysis assess site. The undated Care Plan (CP) reflected that the resident goals were to be free from complications associated with [redacted]. The CP indicated that the resident had a [redacted] and that the access site was monitored for signs and symptoms of complications, however there were no specific complications listed as to what the nurse were to monitor or the frequency as to how often it was to be monitored. The surveyor reviewed the Clinical Notes Reports for May 2021 and there was no consistent	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 698	Continued From page 9	F 698		

documentation from nursing department that indicated Resident #[Executive Order 26, 4.b.] access site was monitored/assessed for complications such as bleeding or S/S of infection or patency.

On [Executive Order 26, 4] at 12:31 PM, in the presence of the survey team, the surveyor interviewed the Director of Nursing (DON) who stated that [Executive Order 2] access site monitoring was a nursing intervention listed on the Care Plan (CP). When the DON was asked how the nurses were to know what type of monitoring the [Executive Order 2] access site required, she stated that it was listed on the CP. The DON did not have an answer as to why the CP was not resident specific or why there was not a list of specific complications that the nurses were to monitor for the [Executive Order 26, 4.b.] access site. The DON added that [Executive Order 2] access site monitoring did not require a physician order and did not need to be documented in the TAR to ensure accountability. She stated that the facility documented by exception and only if there was problem. She then stated that the physician order operating system in the computer did not allow for these type orders and that monitoring a [Executive Order 2] access site was not a physician order and reiterated it was a nursing intervention.

On 05/10/21 at 12: 40 PM, the surveyor interviewed the Registered Nurse Staff Coordinator (RNSC) who was responsible for nursing education and competencies who stated that the facility did not have specific education or competencies for the nurses related to AV fistula access care. The RNSC and DON agreed that they could not be 100% certain that the nurses knew how to monitor for complications of a [Executive Order 26] access site if it the procedures were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

(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 698	Continued From page 10 documented. On 05/11/21 at 09:09 AM, the surveyors interviewed the DON who stated that the CP, "was not as descriptive as I would have liked it to be". The DON stated that staff would need to make sure that there was no bruising or bleeding and to ensure that the resident's [redacted] The facility policy titled, "Dialysis" with a revised date of 04/2019, reflected that the facilities will establish a process for each resident receiving care and services for the provision of hemodialysis and or peritoneal dialysis consistent with professional standards of practice. The policy will establish a process for residents who require dialysis receive services, consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences. The policy did not reflect how the facility will monitor or care for dialysis access sites. The facility policy titled "Care/Service Plans" with a revised date of 04/2019, indicated that the Purpose/Scope was that each guest/resident will have individualized Care/Services plan developed. Care/Services Plans will include guest/resident preferences, strengths, routines, personal and cultural preferences, and choices as well as clinical needs. The policy also indicated that each guest/resident will have an individualized care/service plan developed at the time of admission/readmission and that the care/service plan will be revised to reflect any changes in condition. NJAC 8:39-11.2(d)	F 698		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING _____ B. WING _____	05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST/MOUNTAINVIEW GARDENS	**4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444**

(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