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 _____	C 05/25/2023

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 Complaint #'s NJ00154882, NJ00151515, NJ00149153, Survey Date: 5/25/23 Census: 111 Sample: 23 + 3 closed records + 3 complaints = 29 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.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623		6/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/08/2023

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 623	Continued From page 1 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623		

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F 623	Continued From page 2 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to notify the resident or the resident's representative	F 623	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice?	

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F 623	Continued From page 3 in writing for a facility-initiated transfer to the hospital. This deficient practice was identified for 2 of 2 residents (Resident #103 and #111) reviewed for Ex Order 26. 4B1 . The deficient practice was evidenced by the following: 1. On 5/17/23 at 1:31 PM, the surveyor reviewed the hybrid medical records (paper and electronic) of Resident #103. The medical record revealed that the resident was transferred to the Ex Order 26. 4B1 on Ex Order 26. 4B1 . According to the Discharge Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated Ex Order 26. 4B1 , reflected that Resident #103 was discharged to the Ex Order 26. 4B1 with a return anticipated to the facility. On 5/23/23 at 1:15 PM, the surveyor discussed the transfer of Resident #103 to the Ex Order 26. 4B1 with the Licensed Nursing Home Administrator (LNHA) regarding written notification of discharge. The Administrator stated that no written notification was sent to the family or responsible party when Resident #103 was transferred to the Ex Order 26. 4B1 . 2. On 5/24/23 at 11:04 AM, the surveyor reviewed the hybrid medical records for Resident #111, which indicated the resident was transferred to the Ex Order 26. 4B1 in Ex Order 26. 4B1 . The Discharge MDS with a reference date of Ex Order 26. 4B1 , reflected that Resident #111 was discharged to the Ex Order 26. 4B1 with a return anticipated to the facility.	F 623	Resident 103 has since returned to the facility in which case written notification was not needed. Resident 111 has since returned to her home on campus in Independent Living in which case written notification was not needed. 2. How other residents with the potential to be affected by the same deficient practice will be identified? The social workers or designee has completed a record audit for all residents having experienced a facility-initiated transfer in the last 30 days to ensure that the resident or residents' representatives have been notified in writing of the transfer. Any incidences of noncompliance have been corrected promptly. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The administrator or designee has provided education regarding the facility policy for facility-initiated transfers to the social workers, leadership team and licensed nurses. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? The social worker or designee has completed and will continue a record audit weekly for all residents having experienced a facility-initiated transfer to ensure that the resident or residents' representative have been notified in	

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F 623	Continued From page 4 On 5/24/23 at 11:35 AM, the LNHA notified the surveyor that there was no documentation that the facility had notified the resident or resident representative in writing regarding the reason for transfer to the [redacted]. On 5/24/23 at 3:07 PM, the surveyor informed the LNHA and Director of Nursing of the above concerns. On 5/25/23 at 10:35 AM, the LNHA and DON met with the survey team. The LNHA acknowledged that written notification to the resident or their representative was not being provided, as they thought verbal notification was sufficient and were not aware notification in writing had to be provided. A review of the facility's policy titled, "Skilled Nursing Initiated Transfer/Discharge" with a version date of 6/2021 indicated under Procedure: "3. Prior to Continuing Care initiating transfer or discharge, the resident and resident representative must be notified of the reason for discharge in writing and in a language and manner in which they understand. The written notice must include the following: a. Reason for transfer or discharge ... b. effective date of transfer or discharge ...c. Location to which the resident is transferred or discharged ...a. Statement of the resident's appeal rights ...d. Name Address and telephone number of the Office of the Ombudsman ...7. If a resident is temporarily transferred on an emergency basis to an acute care facility (facility initiated transfer), the notice of transfer must be provided to the resident and resident representative as soon as possible both verbally and in writing."	F 623	writing of the transfer for one month and then monthly for two months. Any incidences of noncompliance will be corrected promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and education may be determined based on audit findings. 5. Date of completion: 06/15/2023	

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F 623	Continued From page 5	F 623		
F 638 SS=D	NJAC 8:39-4.1(a)32 Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set (MDS), an assessment tool, for 1 of 26 residents, Resident # 17, system selected for MDS over 120 days and was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS was within 92 days after the ARD of the previous MDS and; 2). the completion date was no later than 14 days after the ARD. On 5/24/23 at 9:30 AM, the surveyor reviewed the medical records of Resident #17. A review of the MDS for Resident #17 revealed that a Quarterly	F 638	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? The MDS coordinator has completed, locked and transmitted the [redacted] quarterly MDS assessment for resident #17. 2. How other residents with the potential to be affected by the same deficient practice will be identified? The MDS Coordinator or designee has completed an audit of all current residents to ensure that quarterly MDS assessments have been completed, and are scheduled, at least every 92 days in between comprehensive assessments. Any incidences of noncompliance have been corrected promptly. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The Corporate Director of Reimbursement	6/15/23

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F 638	Continued From page 6 MDS with an ARD of [redacted] was completed. The next quarterly assessment was due to be completed [redacted], which was not initiated or completed. On 5/24/23 at 9:38 AM, the surveyor interviewed the full-time Registered Nurse/MDS (RN/MDS) coordinator who was responsible for completing the assessments. The RN/MDS coordinator reviewed the completed MDS assessments of Resident #17 with the surveyor. The RN/MDS coordinator agreed that a quarterly MDS assessment should have been completed in [redacted]. The RN/MDS coordinator acknowledged it was her responsibility to ensure that the resident's MDS assessment were accurately initiated and completed. On 5/24/23 at 3:07 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), and Director of Nursing (DON) of the above concerns. On 5/25/23 at 10:35 AM, the DON and LNHA met with the survey team and provided an MDS completion and management policy. A review of the facility's policy titled, "MDS Completion and Management" with a version date of 6/2021, under Policy read: "Resident Assessments will be completed for all residents accurately and in compliance with the most current RAI 3.0 User's Manual." On 5/25/23 at 2:00 PM, the surveyor met with the DON and LNHA who provided no further information.	F 638	or designee has provided education to the MDS coordinator and the MDS contributing members of the interdisciplinary team regarding the facility policy for completion of quarterly assessments at least every 92 days in between comprehensive assessments. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? The director of nursing or designee has completed and will continue an audit of MDS assessments for residents who are scheduled for a quarterly MDS assessment to ensure the assessment has been completed, at least every 92 days in between comprehensive assessments, for each resident for one month and then monthly for two months. Any noted concerns will be addressed immediately. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and education may be determined based on audit findings. 5. Date of completion: 06/15/23	

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F 638	Continued From page 7	F 638		
F 656 SS=D	NJAC 8:39 - 11.2(h) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656		6/15/23

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F 656	Continued From page 8 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a comprehensive person-centered care plan for a resident under *Ex Order 26. 4B1* [redacted]. This deficient practice was identified for 2 of 4 residents reviewed for Ex Order 26. 4B1 [redacted], Resident #21 and Resident #35 and was evidenced by the following: 1. On 5/18/23 at 12:10 PM, the surveyor observed a "STOP" sign posted right outside Resident #21's room door. There was also signage indicating '*Ex Order 26. 4B1* [redacted]." On 5/18/23 at 1:53 PM, the surveyor reviewed the hybrid medical records for Resident #21. According to the resident's Admission record, the resident was admitted to the facility with diagnoses which included but were not limited to, *Ex Order 26. 4B1* [redacted].	F 656	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? Resident #21 comprehensive Ex Order 26. 4B1 [redacted] has been reviewed and updated by the interdisciplinary team to include Ex Order 26. 4B1 to ensure they are individualized and address the residents' personal goals, needs and preferences. Resident #35 comprehensive Ex Order 26. 4B1 [redacted] has been reviewed and updated by the interdisciplinary team to include Ex Order 26. 4B1 to ensure they are individualized and address the residents' personal goals, needs and preferences. 2. How other residents with the potential to be affected by the same deficient practice will be identified? The director of nursing or designee has completed an audit of all current residents receiving hospice services to ensure that each resident receiving hospice services has a personalized hospice care plan which reflects their individual goals, needs and preferences. 3. What measures will be put into place	

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F 656	Continued From page 9 A review of the Significant Change in status assessment Minimum Data Set (SCSA/MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1 reflecting that the resident had a Ex Order 26. 4B1 score of , indicating Ex Order 26. 4B1 that Resident #21 had Ex Order 26. 4B1 . Further review of the SCSA/MDS revealed that Resident #21 was under Ex Order 26. 4B1 . On 5/18/23 at 2:00 PM, surveyor interviewed the nurse assigned to Resident #21 who stated that the resident's care plan was located in a separate binder from the resident's chart. A review of the resident's person-centered care plan revealed that there was no Ex Order 26. 4B1 included for Resident #21 who was receiving Ex Order 26. 4B1 from Ex Order 26. 4B1 . 2. On 5/23/23 at 11:35 AM, the surveyor reviewed the hybrid medical records for Resident #35. According to the resident's Admission record, the resident was admitted to the facility with diagnoses which included, but were not limited to, Ex Order 26. 4B1 . A review of the Quarterly MDS, dated Ex Order 26. 4B1 reflected that the resident could not have a Ex Order 26. 4B1 evaluation, and was documented " Ex Order 26. 4B1 " with Ex Order 26. 4B1 . Further review of the Quarterly MDS revealed that	F 656	or what systemic changes will be made to ensure that the deficient practice does not recur? The DON or designee has provided education to the interdisciplinary team and the nursing staff regarding the facility care plan policy as it pertains to the development and implementation of a comprehensive hospice care plan to ensure that each resident receiving hospice services has a personalized hospice care plan which reflects their individual goals, needs and preferences. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? The director of nursing or designee has completed and will continue weekly care plan audits of all residents receiving hospice services to ensure that each resident receiving hospice services has a personalized hospice care plan which reflects their individual goals, needs and preferences for one month and then monthly for two months. Any noted concerns will be addressed immediately. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and education may be determined based on audit findings. Date of completion: 6/15/23	

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F 656	Continued From page 10 Resident #35 was under Ex Order 26. 4B1. On 5/23/23 at 11:50 AM, surveyor interviewed the nurse assigned to Resident #35 who stated that the resident's care plan was located in a separate binder from the resident's chart. A review of the resident's person-centered care plan revealed that there was no Ex Order 26. 4B1 included for Resident #35 who was receiving Ex Order 26. 4B1 as of Ex Order 26. 4B1. . On 5/24/23 at 3:00 PM, the surveyor reviewed and discussed the above concerns with the facility's License Nursing Home Administrator and Director of Nursing who both agreed that there was no resident centered care plan addressing the that the residents were under hospice care. No further information was provided. NJAC8:39-11.2(c)	F 656		

New Jersey Department of Health

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(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) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.	S 560	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? The facility has put measures in place to ensure the required direct care staff to resident ratios are met daily on all shifts. The facility has placed job postings, advertisements, referral bonuses, and contracted with agencies to recruit for all open certified nurse aide positions. 2. How other residents with the potential to be affected by the same deficient practice will be identified? The administrator or designee has reviewed the daily staffing for the last 2 weeks to validate that the facility met the minimum staffing requirements for	6/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/08/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60922	A. BUILDING: _____ B. WING _____	C 05/25/2023

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) COMPLETE DATE
S 560	Continued From page 1 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the	S 560	certified nursing aides. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? The administrator or designee has provided education regarding the required direct care staff to resident ratios to the clinical leadership staff and the scheduler. The facility has placed job postings and advertisements for all open certified nurse aide positions. The administrator or designee has pursued securing direct care staffing services from staffing agencies. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? The administrator or designee has reviewed and will continue to review the certified nurse aide staffing and resident census to ensure compliance with the required direct care staff to resident ratios daily for one month and then weekly for 2 months. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and education may be determined based on audit findings. 5. Date of completion: 06/15/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60922	A. BUILDING: _____ B. WING _____	C 05/25/2023

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) COMPLETE DATE
S 560	Continued From page 2 midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 4/30/23 to 5/6/23 and 5/7/23 to 5/13/23 revealing that the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 2 of 14 day shifts as follows: The facility was deficient in CNA staffing for residents on 2 of 14 day shifts from 4/30/23 to 5/13/23 as follows: -On 4/30/23 the facility had 12 CNAs for 113 residents on the day shift but required 14 CNAs. -On 5/07/23 the facility had 13 CNAs for 112 residents on the day shift but required 14 CNAs. On 5/18/23 at 1:49 PM, the surveyor informed the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) of their deficient staffing practice on 2 days, 4/30/23 and 5/7/23. The DON informed the surveyor that there was a sick call by a CNA on both days. No further information was provided.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315491 Y1	A. Building B. Wing Y2	6/29/2023 Y3

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

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 F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 06/15/2023	ID Prefix F0638 Reg. # 483.20(c) LSC	Correction Completed 06/15/2023	ID Prefix F0656 Reg. # 483.21(b)(1)(3) 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
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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	
5/25/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60922 Y1	A. Building B. Wing Y2	6/29/2023 Y3

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

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 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 5/25/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: K23K12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315491	A. BUILDING **01** B. WING _____	**05/25/2023**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 05/22/2023. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/22/23 was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Cedar Crest/Mountainview Gardens is a three-story building with basement that was built in 2005 and 2008. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 50 % of the building as per the facility Maintenance Supervisor. The current occupied beds are 110 of 113.	K 000		

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

Electronically Signed | 06/08/2023

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.