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 _____	09/13/2024

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 STANDARD SURVEY: 9/4-9/10/24 CENSUS: 111 SAMPLE SIZE: 23+2 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 1 of 25 residents reviewed (Resident # 113). The deficient practice was evidenced by the following: The surveyor reviewed Resident # 113's records. The resident reviewed [NJ Ex Order 26.4], was discharged from the facility and according to the Discharge Return Anticipated MDS, an assessment tool used to facilitate the management of care, dated [NJ Ex Order 26.4], the Type of Discharge was indicated as unplanned. A review of Resident # 113's progress notes	F 641	Failure of F641 "Accuracy of Assessments," CFR(s):483.20(g) 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. The MDS coordinator has corrected, completed, locked and transmitted the [NJ Ex Order 26.4(b)(1)] discharge MDS assessment for resident #113. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. The MDS Coordinator or designee has completed an audit of the Discharge MDS assessments from 6/1/24 through 9/23/24 to ensure that the correct type of discharge was indicated on the tool. Any	10/15/24

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

Electronically Signed | 09/26/2024

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F 641	Continued From page 1 dated NJ Ex Order 26.4, revealed the resident had a planned discharged to an NJ Ex Order 26.4(b)(1) [redacted] On 9/9/24 at 12:20 PM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that the MDS under section A Typer of Discharge for Resident # 113 should have indicated that the resident's discharge was planned. During an interview on 9/9/24 at 1:20 PM, the surveyor brought the above concerns to the attention of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) A review of the policy titled MDS completion and Management policy, revealed " Resident Assessments will be completed for all residents accurately." NJAC 8:39-11.2(e)1	F 641	incidences of noncompliance were 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? a. The Corporate Director of Reimbursement or designee has provided education to the U.S. FOIA (b) (6) and the MDS contributing members of the interdisciplinary team regarding the facility policy for MDS assessments, including selecting the correct assessment type and accuracy of type of discharge. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The director of nursing or designee will complete an audit of all Discharge MDS assessments for each discharged resident for one month followed by an audit of 25% of Discharge MDS assessments monthly for one quarter. The audit will review the Discharge MDS assessments to ensure that the correct assessment type and type of discharge was selected. Any concerns found will be addressed 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: 10/15/24	

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F 658	Continued From page 2	F 658		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility polices it was determined that the facility failed to: a.) carry out medication orders for a NJ Ex Order 26.4 resident and b.) clarify an NJ Ex Order 26. order. This deficient practice was identified for 2 of 12 Residents (Resident #67 and #3) reviewed. The deficient practices were evidenced by the following: 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, 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	F 658	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? The NJ Exec Order 26 recommendations for resident #67 were reviewed with the provider and carried out. The NJ Ex Order 26. order for resident #3 was clarified with the provider and updated accordingly upon NJ Exec readmission on NJ Exec Order 26. 2. How other residents with the potential to be affected by the same deficient practice will be identified? The director of nursing or designee audited the hospice recommendations for all residents receiving hospice services to ensure that they were reviewed with the provider and carried out appropriately if ordered. Any incidences of noncompliance were corrected promptly. The director of nursing or designee audited the oxygen therapy orders for all residents receiving oxygen therapy to ensure that the orders were clear and complete. Any incidences of noncompliance were corrected promptly.	10/15/24

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F 658	Continued From page 3 nurse is defined as performing tasks and responsibilities within the framework of case finding; 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." 1. On 9/4/24 at 10:42 AM, the surveyor observed Resident #67 in their room, in bed. Resident stated they are NJ Ex Order 26.4(b)(1) but varies on the NJ Ex Order 26.4(b)(1) The surveyor reviewed Resident #67 paper and electronic medical chart which revealed the following: A review of the Resident #67's Admission Record (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1). A Significant Change Minimum Data Set ((MDS) an assessment tool used for the management of care) date NJ Ex Order 2, documented under Section NJ E indicating the resident is NJ Ex Order 26.4(b)(1) In the NJ Exec Order 26 section of the paper chart, the surveyor observed a paper titled, "Supplemental Interdisciplinary Progress Note" dated NJ Ex Order 2, with medication recommendations for: 1. " NJ Ex Order 26.4(b)(every (q) hour, per resident request (PRN) for NJ Ex Order 26.4(b)(1) or other signs and symptoms (s/s) of NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1)." 2. " NJ Ex Order 26.4(b)(1	F 658	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 director of nursing or designee provided education to the licensed nurses on the facility policy regarding the process for reviewing and carrying out hospice recommendations The director of nursing or designee provided education to the licensed nurses on the facility policy regarding the need to clarify unclear or incomplete oxygen therapy orders with the provider. 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 will complete weekly audits of all hospice recommendations to ensure that they have been reviewed with the provider, and carried out appropriately if ordered, for one month and then monthly for two months. Any noted concerns will be addressed 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. The director of nursing or designee will complete weekly audits of all oxygen	

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F 658	Continued From page 4 NJ Ex Order 26.4(b)(1), PRN for NJ Ex Order 26. or NJ Ex Order 26.4(b)(1)." The progress note was signed by the Licensed Practical Nurse (LPN #1) from NJ Ex Order 26.4(b)(1) and was initialed by "NJ Ex Or who is the Nurse Practitioner (NP#1) for Resident #67. A review of the NJ Exec Order 2 and NJ Exec Order 26.4b1 Physician Orders (PO) included a PO dated NJ Ex Order 26.4(b that read, "1. "NJ Ex Order 26.4(b)(1) (2) TABLET oral by mouth every 6 hours as needed for NJ Ex Order 26.4(b)(1))", dated NJ Ex Order 26.4. Indication NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). 2. "NJ Ex Order 26.4(b)(1) tablet (1 tab) Tablet Oral. Indication: NJ Ex Order 26.4(b)(1)." NJ Ex Order 26.4(b)(and NJ Ex Order 2 were not observed in the PO in either the paper or electronic record. A review of the Physician's Orders Form in the paper chart, revealed on NJ Ex Order 2, NJ Ex Order 2 and NJ Ex Order 26.4 the chart had been reviewed by the 11PM to 7AM nurse had completed a "24 hour chart review" without ordering the NJ Ex Order 26.4(b)(and NJ Ex Order 2 medications. A review of the NJ Exec Order 26 "Skilled Nursing Visit Note" in the paper chart revealed on NJ Ex Order 2, NJ Ex Order 26.4, and NJ Ex Order 26.4 and NJ Ex Order 26.4, Registered Nurse (RN#1) for the NJ Ex Order 26.4(assessed and completed the current NJ Ex Order 26.4(b)(1) regiment for Resident #67 but did see the missing NJ Ex Or medication orders. On 9/5/24 at 11:31 AM, the surveyor interviewed LPN#2, who is regular 7AM-3PM nurse for Resident #67. The LPN#2 reviewed current medications for the resident and did not see any orders for NJ Ex Order 26.4(b)(or NJ Ex Order 26 Surveyor and LPN#2 reviewed the NJ Ex Order 26.4 paper progress note	F 658	therapy orders for clarity and completeness for one month and then monthly for two months. Any noted concerns will be addressed 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.	

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F 658	Continued From page 5	F 658		

from [NJ Ex Order 2], and LPN#1 confirmed [NJ Ex Order 26.4(b)(] and [NJ Ex Order 2] were recommended, initialed by the NP#1, and the orders were not carried out. No further comment made.

On 9/5/24 at 11:45 AM, the surveyor interviewed the [NJ Exec] floor Clinical Manager (CM#1), who stated the process for carrying out medications for a [NJ Ex Order 26.4] resident is the [NJ Ex Order 26.4] nurse will write out medication recommendations, the resident's doctor or nurse practitioner will review and initial the [NJ Ex Order 26.4] recommendation paper indicating to carry out the order, and the nurse will carry out the order. The CM#1 acknowledged the [NJ Exec Order 26] paper was initialed by the NP#1 and the [NJ Ex Order 26.4(b)(] and [NJ Ex Order 2] orders were not carried out by the nurse. The CM#1 was unable to explain why the order was not carried out.

On 9/5/24 at 12:18 PM, the surveyor interviewed the LPN#1 who is the current U.S. FOIA (b) (6) for Resident #67. The LPN#1 stated, they had written the recommendations for [NJ Ex Order 2] and [NJ Ex Order 26.4(b)(] as they are standard recommendations. The LPN#2 further stated they come in twice per week but was unaware those medications had not been ordered. The LPN#1 stated they have not done their monthly medication review yet and was planned to be done tomorrow. The LPN#1 could not explain why RN#1 had not seen the missing medications orders. The RN#1 was unable to be reached for interview.

On 9/5/24 at 1:13 PM the U.S. FOIA (b) (6) [redacted] provided the surveyor with two facility polices titled, Hospice Program and Physician Orders both with revision dates of 5/2021. The Hospice Program policy states under the procedure section, "5. The

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F 658	Continued From page 6	F 658		

hospice agency works in conjunction with the continuing care/clinical staff to implement the integrated plan of care: a. Designated hospice registered nursing coordinates the implementation of the plan of care ...c. Provision of drugs and medical supplies as needed for palliation and management of the terminal illness and related conditions; and d. Involvement of facility personnel in assisting with the administration of prescribed therapies in the plan of care." The Physician Orders policy states under the procedure section, "When the resident is under the care of hospice, orders received by a nurse working for the hospice will be confirmed by a licensed nurse employed by the continuing care and approved by the attending physician employed by the community/EHMG."

On 9/6/24 at 12:59 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to review the above mentioned concerns. No comments made at that time.

2. On 9/04/24 at 11:02 AM, the surveyor observed Resident #3 in bed watching television. The surveyor observed the resident was receiving NJ Ex Order 26.4(b)(1) The NJ Ex Order 26.4(b)(1) was labeled and dated NJ Ex Order 26.4

A review of Resident #3's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)

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NJ Ex Order 26), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Ex Order 2, reflected that the resident's NJ Exec Order 26.4(skills for NJ Exec O score was NJ E out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) .

A review of the NJ Ex Order 26.4(b)(1) Physician Order Sheet (POS) revealed a Physician's Order (PO) dated NJ Ex Order 26.4(b for NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) at bedtime (HS) to maintain NJ Ex Order 26.4(b)(1)

A review of the NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) electronic Treatment Administration Record (ETAR) revealed an order dated NJ Ex Order 26.4(b for NJ Ex Order 26.4(b)(1) to give NJ Ex Order 26 at NJ Ex O A further review of the ETAR revealed that NJ Ex Order 26.4 was signed as being administered during the 3-11 PM shift.

A review of the comprehensive care plan revealed a care area dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 care with a goal that the resident won't have "signs and symptoms of NJ Ex Order 26.4(b)(1)". The care plan indicated that the resident required NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4(b)(1) that included the resident would NJ Ex Order 26.4(b)(1) in keeping " NJ Ex Order 26. and maintain the prescribed NJ Ex Ord to be administered at all times". The care

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F 658	Continued From page 8 plan also revealed under method of administration that the resident will be receiving NJ Ex Order 26.4(b)(1) as needed to maintain [redacted]" On 9/6/24 at 9:20 AM, the surveyor and the Licensed Practical Nurse (LPN#3), reviewed Resident #3's order for [redacted] The LPN #3 acknowledged that the resident was receiving [redacted] via a NJ Ex Order 26.4(b)(1) [redacted]. After reviewing the resident's [redacted] order, LPN #3 stated that the order should have been clarified with the physician and that it should have been written for either [redacted] or [redacted] On 9/06/24 at 1:00 PM, the surveyor presented the above concerns to the U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted] There was no additional information provided. A review of the facility's policy entitled, "Physician Orders" dated 5/202 included the following: "Policy: Incomplete or illegible orders will always be clarified before being implemented."' NJAC 8:39-11.2(b), 19.4 (a) (1)	F 658		
F 812 SS=F	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	F 812		10/15/24

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F 812	Continued From page 9 from local producers, subject to applicable State and local laws or regulations. (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 facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 9/4/24 at 9:21 AM, the surveyor in the presence of the U.S. FOIA (b) (6)) observed the following during the kitchen tour: 1. On the preparatory table, the surveyor observed the can opener with a caked on black colored debris. The U.S. FOIA stated, they were unsure when the can opener was cleaned last, but the can opener would be cleaned immediately. 2. In the cooking area of the kitchen, the surveyor observed the standing dual oven with a sticky yellowish substance and dust like particles on top of the oven. U.S. FOIA not sure when the oven was last cleaned was last cleaned.	F 812	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? The can opener, dual standing oven, deep fryer, and standing combination oven were cleaned per facility policy promptly by the dining services utility worker. Education regarding cleaning and sanitization of kitchen equipment was completed by staff who utilize and are responsible for cleaning the equipment. 2. How other residents with the potential to be affected by the same deficient practice will be identified? Sanitation and cleaning schedule audits were completed on a daily basis to ensure that dining services staff are following the facility policies for cleaning and sanitizing kitchen equipment. Dining manager or designee will continue to audit	

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F 812	Continued From page 10 3. The deep fryer was observed with multiple food crumbs around the inside of the fryer. Per Chef #1 the fryer was not used today, unable to explain why food crumbs were present and not cleaned last night after use. 4. The standing combination oven was observed with a grease like substance on top of the oven. The U.S. FOIA was unable to state when the last time for oven was cleaned but would address the issues immediately. On 9/5/24 at 9:55 AM, the U.S. FOIA (b) (6) provided the surveyor with two facility policies including Cleaning and Sanitizing Food Contact Surfaces and Cleaning and Sanitizing Major Cooking Equipment both with a revised date of 1/2024. The including Cleaning & Sanitizing Food Contact Surfaces Cleaning states under the standards of practice (SOP) section, "All food contact surfaces will be cleaned and sanitized at the beginning of each shift, prior to use, end of use and in between tasks." The Cleaning and Sanitizing Major Cooking Equipment states under the SOP section, "Thorough cleaning and sanitizing of all cooking equipment and equipment supporting cooking is vital to the prevention of food borne illnesses and the safety of our employees. Specific examples of cleaning equipment will be documented in sperate SOP's as necessary." The procedure section of the policy states, "All Food Service Cooking and preparation Equipment will be cleaned and sanitized after each use and maintained in a clean and sanitized condition." On 9/6/24 at 12:59 PM, the survey team met with the U.S. FOIA (b) (6)	F 812	the schedule daily for one month followed by monthly audits for one quarter. Any incidences of noncompliance were 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 dining manager or designee has provided education to the dining staff regarding the facility policies for cleaning and sanitation 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? The dining manager or designee will complete daily audits for one month to ensure cleaning and sanitation schedules are being completed. Dining manager or designee will continue to audit the schedule daily for one month followed by monthly audits for one quarter. The audits will ensure that the dining staff are following the facility policies for cleaning and sanitation. Any concerns found 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.	

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 _____	09/13/2024

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CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

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F 812	Continued From page 11 U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) to review concerns. The U.S. FOIA (b) (6) and U.S. FOIA had no comments for the above mentioned concerns. NJAC 8:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		10/15/24

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F 880	Continued From page 12 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene and	F 880	Failure of F880 “Infection Prevention and Control,” CFR(s):483.80(a)(1)(2)(4)(e)(f) 1. What Corrective Action will be taken	

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F 880	Continued From page 13 appropriate use of personal protective equipment (PPE) for 1 of 4 staff observed on 1 of 4 Nursing Units. This deficient practice was evidenced by the following: According to the Center for Disease Control and Prevention (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient ... Before moving from work on a soiled body site to a clean body site on the same patient ... After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. On 9/5/24 at 11:12 AM, the surveyor observed the U.S. FOIA (b) (6)) on the NJ Exec Order 26 Unit, exited room NJ Ex Orde wearing a pair of gloves. The surveyor observed signage outside room NJ Ex Orde which indicated the resident in room NJ Ex Orde was on NJ Ex Order 26.4(b)(1)) which included: everyone must clean their hands, including before entering and when leaving the room; wear gloves and NJ Ex Order 26. for the following High-Contact Resident Care Activities which included...dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use including central line, urinary catheter, feeding tube (gastrostomy tube), tracheostomy; wound care including any skin opening requiring	F 880	for those residents found to have been affected by the deficient practice? a. Education and competency evaluation regarding the facility policies for hand hygiene, personal protective equipment (PPE) use and enhanced barrier precautions was provided to the identified certified nursing assistant (CNA) by the Assistant Director of Nursing. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. Hand hygiene and personal protective equipment use competency evaluation audits for all of the CNAs on each unit were completed by the Director of Nursing or designee to ensure that the nursing staff are following the facility policies for hand hygiene, personal protective equipment (PPE) use and enhanced barrier precautions. Any incidences of noncompliance were 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? a. The Director of Nursing or designee has provided education to the nursing staff regarding the facility policies for hand hygiene, personal protective equipment (PPE) use and enhanced barrier precautions. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The director of nursing or designee will complete weekly hand hygiene and personal protective equipment (PPE) use competency evaluation audits of 10% of	

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F 880	Continued From page 14 a dressing. The surveyor observed the U.S. FOIA went directly from room NJ Ex Orde into room NJ Ex Order and provided care for the resident without removing her gloves and without performing hand hygiene. On that same day, at that same time, the surveyor observed the U.S. FOIA exited room NJ Ex Order walked down the hallway to the nurses' station, requested assistance from the U.S. FOIA (b) (6) on the floor and re-entered room NJ Ex Orde wearing the same soiled gloves, with no observed hand hygiene. On 9/5/24 at 12:25 PM, the surveyor observed meal service on the NJ Exec Order 2 Unit. The surveyor observed the U.S. FOIA entered the communal dining room and obtained a tray, delivered the tray to room NJ Ex Orde and placed the tray on the resident's bed side table with no observed hand hygiene. The surveyor observed signage outside the room which indicated the resident in room NJ Ex Orde was on NJ Ex Orde On 9/5/24 at 12:32 PM, the surveyor discussed the above observations and concerns with the U.S. FOIA (The U.S. FOIA acknowledged that she should have changed her gloves and performed hand hygiene between residents. The U.S. FOIA further stated that she had not been in serviced on NJ Ex Ord and was not aware she should have performed hand hygiene when entering and exiting the rooms of residents who are on NJ Ex Orde On 9/9/24 at 12:01 PM, the surveyor interviewed the U.S. FOIA (b) (6) for the NJ Exec Order 2 Unit who stated that the facility's policy was no gloves were allowed to be worn in the hallways and further stated that all staff were in serviced on NJ Ex Ord policy which included everyone must perform hand	F 880	the nursing staff on each unit for one month followed by monthly competency evaluation audits on each unit for one quarter. The audits will ensure that the nursing staff are following the facility policies for hand hygiene, personal protective equipment (PPE) use and enhanced barrier precautions. Any concerns found will be addressed 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: 10/15/24	

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F 880	Continued From page 15	F 880		

hygiene before entering and exiting rooms.

On 9/9/24 at 12:15 PM, the surveyor discussed the above observations and concerns with the U.S. FOIA (b) (6)) who acknowledged that hand hygiene should be performed according to CDC regulations including between residents and before entering and exiting a resident's room who was on NJ Ex Orde

A review of the Hand Hygiene policy and procedure, dated as revised 3/24 revealed ...the purpose of Hand Hygiene is to prevent the spread of potentially infectious organisms to residents/patients, staff and visitors ...the Center for Disease Control and Prevention (CDC) recognizes two methods for Hand Hygiene ...Alcohol Based Hand Sanitizers (ABHS) are the most effective products for reducing the number of germs on the hands of healthcare providers ...when hands are not visibly dirty, ABHS are the preferred method for cleaning your hands in healthcare settings ...full handwashing with soap and water are required for visibly dirty hands ... When to perform some form of hand hygiene (at a minimum): Immediately before, between and after physical contact with a resident/patient... Before entering or exiting a resident's/patient's room...
Handwashing is required anytime you are handling food; before putting on (donning) and after removing (taking off) PPE, including gloves.

A review of the Enhanced Barrier Precautions (EBP) policy and procedure dated as revised 6/23 revealed...the purpose of EBP...to prevent the potential spread of Multi-Drug Resistant Organisms (MDRO) during high contact care activities of residents with increased risk... EBP

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F 880	Continued From page 16 expand the use of PPE...Hand Hygiene should be performed before and after resident contact...Education regarding this policy will be completed with appropriate personnel as needed... On 9/9/24 at 1:21 PM, no further information was provided by the facility. NJAC 8:39-19.4 (a); (n)	F 880		

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	60922	A. BUILDING: _____ B. WING _____	09/13/2024

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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	S 560	1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? Since the audit on 9/1/2024-9/14/2024, the facility has put measures in place to ensure the required direct care staff to resident ratios are met daily on all shifts. Since the audit, the facility has refreshed job postings, advertisements, transportation assistance programs, referral bonuses, and contracted with a second agency to recruit for all open certified nurse aide positions. The facility has also hired six new CNA's since the completion of the audit.	10/15/24

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

Electronically Signed | 09/26/24

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S 560	Continued From page 1 effective 2/1/21. 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	S 560	In the case of call outs the facility has offered overtime to all aides who are already internal and has instituted a shift bonus for internal staff to pick up last minute coverage. 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 certified nursing assistants. 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 will provide education regarding the required direct care staff to resident ratios to the clinical leadership staff and the US FOIA (b)(6). The facility will continue to place job postings and advertise for all open certified nurse aide positions. The administrator or designee will pursue securing direct care staffing services from staffing agencies and educate staff on shift bonuses internally. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? The administrator or designee will review the certified nurse aide staffing and	

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S 560	Continued From page 2 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 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 weeks of staffing prior to the September 2024 Standard Survey at Cedar Crest Village Mountainview Gardens revealed the following shortages. For the 2 weeks of staffing prior to survey from 08/18/2024 to 08/31/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -08/18/24 had 13 CNAs for 109 residents on the day shift and required at least 14 CNAs. -08/30/24 had 11 CNAs for 109 residents on the day shift and required at least 14 CNAs. The Survey Team informed the Director of Nursing of the deficient staffing ratios on 9/10/24 at 5:00 pm.	S 560	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.	

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S2345	Continued From page 3	S2345		
S2345	8:39-31.6(o) Mandatory Physical Environment (o) The facility shall conduct at least one evacuation drill each year, either simulated or using selected residents. State, county, and municipal emergency management officials shall be invited to attend the drill at least 10 working days in advance. This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/12/2024 and 09/13/2024 in the presence of the Facilities Maintenance Supervisor (FMS) and the Administrator, it was determined that the facility failed to invite state, county, and municipal emergency management officials to at least one evacuation drill at least 10 working days in advance. In an interview on 09/12/2024 at 10:00 AM the surveyor requested documentation regarding collaboration with emergency management officials. The Administrator did provide documentation of a drill conducted on 09/28/2023 as evidence that a drill was conducted but was unable to provide documentation regarding the invitation or attendance of emergency management officials. The facility's DON was notified of the deficient practice at the Life Safety Code exit conference on 09/13/2024 at 2:00 PM.	S2345	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 evacuation drills continue to be conducted and state, county, and municipal emergency management officials have been invited to at least one drill at least ten working days in advance. Further, the facility has scheduled its next drill for October 24, 2024 and has sent invitations to emergency management officials to ensure the ten day notice. 2. How other residents with the potential to be affected by the same deficient practice will be identified? Completed on September 21, 2024, the facility has scheduled and invited emergency management officials for the next evacuation drill on October 24th, 2024.	10/15/24

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S2345	Continued From page 4	S2345	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 will schedule two evacuation drills for each annual year and invite emergency management officials to both, ten working days in advance to ensure compliance. The administrator or designee will have an automatic reminder for both the scheduled drill as well as a reminder to send and print invitation for documentation purposes. 4. How the corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? Evacuation drill findings will be reported to the Quality Assurance Performance Improvement (QAPI) committee for monthly review.	

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	11/1/2024 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 F0641	Correction	ID Prefix F0658	Correction	ID Prefix F0812	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	10/15/2024	LSC	10/15/2024	LSC	10/15/2024
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
9/13/2024	☐ 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)
60922	A. Building B. Wing	11/1/2024

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 10/15/2024	ID Prefix S2345 Reg. # 8:39-31.6(o) LSC	Correction Completed 10/15/2024	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 9/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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 _____	**09/13/2024**

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 Cedar Crest- Mountain View Gardens 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		
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 09/12/2024 and 09/13/2024. Cedar Crest was found to be in non-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 skilled nursing consist of the Rose Court Wing Floors 3, 2, and Terrace. The Terrace floor of the Evergreen wing is also skilled nursing. The facility is 113 beds and the census was 112. the building has 4 elevators and a 300 KW diesel emergency generator that supplies Approximately 65% of the facility as per the Facilities Maintenance Supervisor.	K 000		
K 223 SS=F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke	K 223		10/15/24

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

Electronically Signed | 09/27/2024

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 _____	**09/13/2024**

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
K 223	Continued From page 1 compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/13/2024 in the presence of the Facilities U.S. FOIA (b) (6), U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that smoke barrier doors were kept in the closed position, unless held open by a releasing device in accordance with NFPA 101:2012 Edition, Sections complying with 19.2.2.2.7, and 7.2.1.8.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:00 AM, revealed that the elevator lobby smoke/fire barrier doors on floor 3 of Rose Court were being held open but were not capable of instant manual release. In an interview at the time, The U.S. FOIA confirmed the observation and stated that upon loss of power and fire alarm activation, the doors would automatically release and close. The U.S. FOIA attempted to find the circuit breaker for the barrier doors to show that the doors would close upon loss of power but was unable to locate it. The facility's U.S. FOIA was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM.	K 223	K223 SS=F Doors with Self-Closing Devices CFR(s): NFPA 101:2012 Edition [19.2.2.2.7 and 7.2.1.8.2] 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. A switch has been installed by maintenance supervisor at the elevator lobby smoke/ fire barrier doors allowing the doors to be instantly manually released from the hold-open position. The Facilities Maintenance Supervisor (FMS) and Maintenance Supervisor (MS) have confirmed that upon loss of power and fire alarm activation the doors automatically release and close. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. The FMS and MS have audited all other fire doors to verify the presence and correct functioning of manual instant release mechanisms. Any deficiencies found were promptly corrected. 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. A check of the elevator lobby	

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 _____	**09/13/2024**

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
K 223	Continued From page 2 N.J.A.C 8:39-31.2(e)	K 223	smoke/fire barrier doors has been added to the monthly fire door inspections performed by Security and Emergency Services Department (SES). Confirmation of a correctly functioning instant manual release has been added to the monthly Fire Door Inspection checklist. b. Education on the facility policy to check the lobby smoke/fire barrier doors for instant manual release during the monthly fire door inspections has been provided to the SES Department by the Administrator or designee. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS will audit the correct performance of the manual instant release switch monthly for one quarter. The MS will also audit the binder containing records of inspection monthly for one year for documentation of completed inspections. Any concerns found will be addressed promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/2024	
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in	K 293		10/15/24

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 _____	**09/13/2024**

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
K 293	Continued From page 3 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 observations and interviews on 09/13/2024 in the presence of the [redacted], it was determined that the facility failed to ensure that a sign with directional indicator showing the direction of travel was provided in every location where the direction of travel to reach the nearest exit is not apparent in accordance with NFPA 101:2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:46 PM, revealed that upon exiting of the family kitchen area and headed to the left, there was no directional indicator to the nearest exit on floor 2 of the Rose Court building. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] was notified of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 293	K293 SS=F Exit Signage CFR(s): NFPA 101:2012 Edition [19.2.10.1 and 7.10] 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. Evacuation maps have been placed leaving the family kitchen area to provide directional indicators to the nearest exit 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. All common area spaces exiting into corridors have been audited for directional indicators to the nearest exit by the maintenance supervisor. 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. Education has been provided to the maintenance and security team regarding evacuation maps and directional indicators to nearest exits in the building 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS will complete an audit of all evacuation maps and exit indicators are present per standard. Any concerns found will be addressed immediately. Audit findings will be reported to the Quality	

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 _____	**09/13/2024**

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

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K 293	Continued From page 4	K 293	Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/2024	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)	K 321		10/15/24

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	315491	A. BUILDING **01** B. WING _____	**09/13/2024**

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

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K 321	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/13/2024 in the presence of the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that doors to hazardous areas were protected and their doors were self-closing or automatic closing in accordance with NFPA 101:2012 Edition, Sections 8.7.1, 8.4 and 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:22 PM, revealed that the resident laundry room on floor 2 of Rose Court contained two washer/gas-dryer combo appliances. The door to the laundry room was not provided with a self-closing or automatic closing device. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility's U.S. FOIA [redacted] was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e)	K 321	K321 SS=F Hazardous Areas - Enclosure CFR(s): NFPA 101:2012 Edition [8.7.1, 8.4 and 19.3.5.9] 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. Spring loaded hinges were installed on the door of the floor 2 Rose Court resident laundry room by the Maintenance Supervisor (MS). Automatic self-closing and positive latching was confirmed and documented after installation by the MS. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. The Facility Maintenance Supervisor (FMS) and MS have audited all other resident laundry doors for self-close devices. Any deficiencies found were promptly addressed. 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. A check of the resident laundry room doors has been added to the monthly fire door inspections performed by Security and Emergency Services Department (SES). Confirmation of self-closing and latching has been added to the monthly Fire Door Inspection checklist. b. Education on the facility policy to check the resident laundry room doors for self-closing and latching during the monthly fire door inspections has been provided to the SES Department by the Administrator or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 6	K 321	4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS will complete an audit of all resident laundry doors to confirm correct self-closing behavior monthly for one quarter. The MS will also audit the binder containing records of inspection monthly for one year for documentation of completed inspections. Any concerns found will be addressed immediately. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/24	
K 324 SS=F	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	K 324		10/31/24

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	315491	A. BUILDING **01** B. WING _____	**09/13/2024**

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

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K 324	Continued From page 7 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 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/12/2024 and 09/13/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the kitchen suppression system was inspected semi-annually in accordance with NFPA 96, Standard for the Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice had the potential to affect all residents and was evidenced by the following: In an interview on 9/12/2024 at 9:00 AM during the Life Safety Code entrance conference, the surveyor made a requested for the semi-annual inspection of the kitchen suppression system to the U.S. FOIA (Documentation review revealed that kitchen Ansul inspections were dated 09/12/23 and 05/03/24, nearly 8-months later. In an interview at 3:00 PM the surveyor requested for the U.S. FOIA to provide any additional kitchen Ansul inspections for review the following morning. No further documentation was provided.	K 324	K324 SS=F Cooking Facilities CFR(s): NFPA 101 [NFPA 96, Standard for the Ventilation Control and Fire Protection of Commercial Cooking Operations] 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. The next semi-annual inspection of the kitchen suppression system has been scheduled for 10/31/2024 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. NJ Ex Order 26.4(b)(1), our fire suppression vendor, has been updated with our semi-annual requirements and will be scheduled on an automatic visit cadence 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. Education has been provided to the maintenance team regarding the facility policy for semi-annual inspections of the kitchen suppression system to include the requirement for the semi-annual inspections to be separate by no more than 6 months.	

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K 324	Continued From page 8 The facility's U.S. FOIA was notified of the deficient practice at the Life Safety Code exit conference on 09/13/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 96	K 324	4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS will audit the binder containing records of inspection monthly for one year for documentation of completed inspections. Any concerns found will be addressed immediately. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/24	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/12/2024 and 09/13/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that semi-annual fire alarm inspections were conducted in accordance with NFPA 101:2012 Edition, Sections 9.6.1.3, 9.6.1.5, NFPA 70 and NFPA 72. This deficient practice had the potential to affect all residents and was evidenced by the	K 345	K345 SS=F Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101:2012 Edition [9.6.1.3 and 9.6.1.5], NFPA 70 and NFPA 72 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. The next inspection of the fire alarm system has been scheduled for October	10/28/24

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CEDAR CREST/MOUNTAINVIEW GARDENS	**4 CEDAR CREST VILLAGE DRIVE** **POMPTON PLAINS, NJ 07444**

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K 345	Continued From page 9 following: In an interview on 9/12/2024 at 9:00 AM during the Life Safety Code entrance conference, the surveyor made a requested for the fire alarm system semiannual inspection to the [US FOIA (b)] Documentation review revealed that fire alarm inspections were dated 02/21/23 and 03/26/24, more than 13-months later. In an interview at 3:00 PM the surveyor requested from the [U.S. FOIA] to have any addition fire alarm inspections provided for review the following morning. No further documentation was provided. The facility's [U.S. FOIA] was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 70, 72	K 345	15, 2024, the next available date our vendor could provide 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. [NJ Ex Order 26.4] our fire alarm vendor, has been updated with our semi-annual requirements and will be scheduled on an automatic visit cadence 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. Education has been provided to the maintenance team regarding the facility policy for semi-annual inspections of the fire alarm system to include the requirement for the semi-annual inspections to be separate by no more than 6 months. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS will audit the binder containing records of inspection monthly for one year for documentation of completed inspections. Any concerns found will be addressed immediately. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/28/24	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101	K 351		10/15/24

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	315491	A. BUILDING **01** B. WING _____	**09/13/2024**

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

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K 351	Continued From page 10 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/13/2024 in the presence of the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that fire sprinkler protection was provided in all closets and that missing escutcheon were replaced in accordance with NFPA 101:2012 Edition, Section 19.3.5.1, 9.7, NFPA 13 Standard for the Installation of Sprinkler Systems and NFPA 25. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:32 AM, revealed a closet that exceeded 2 ft x 2 ft in Evergreens physical therapy room that was not provided with sprinkler protection.	K 351	K351 SS=F Sprinkler System - Installation CFR(s): NFPA 101:2012 Edition [19.3.5.1 and 9.7], NFPA 13 Standard for the Installation of Sprinkler Systems, and NFPA 25 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. The closet exceeding 2 ft x 2 ft in the Evergreen physical therapy room was demolished by the Maintenance Supervisor (MS) and contractors, eliminating the space that was not provided with sprinkler protection. b. The missing escutcheon was replaced in the Evergreen elevator room by the MS. 2. How other residents with the potential	

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K 351	Continued From page 11 An observation at 11:37 AM, revealed that there was a sprinkler escutcheon missing in the Evergreen elevator room. In interviews at the time, the [U.S. FOIA] confirmed the observations. The facility's [U.S. FOIA] was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 13, 25	K 351	to be affected by the same deficient practice will be identified? a. The Facility Maintenance Supervisor (FMS) and MS have audited all other closets for the presence of sprinkler protection. Any incidences of noncompliance were addressed 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? a. Education was provided to the maintenance team by the administrator or designee regarding the facility policy for sprinkler coverage in closets. b. Education was provided to the maintenance team by the administrator or designee regarding the facility policy for presence of escutcheons. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. Any changed spaces and the presence and correct installation of escutcheons will documented and audited by the MS during monthly rounds. Any concerns found will be addressed immediately. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/24	
K 361 SS=F	Corridors - Areas Open to Corridor CFR(s): NFPA 101	K 361		10/28/24

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K 361	Continued From page 12 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/13/2024 in the presence of the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA 101:2012 Edition, Section 19.3.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:06 AM and 12:31 PM, revealed that floors 2 and 3 of the Rose Court building each contained a family kitchen area, activity room and a library/living room that were open to the corridor and in the same smoke compartment. There was no evidence of supervised automatic smoke detection in the any of the spaces that were open to the corridor. In interviews at the time of the observations, the U.S. FOIA [redacted] confirmed the observations. The U.S. FOIA [redacted] stated that he believed that there were smoke dampers, but he was not sure where they were located. The facility's U.S. FOIA [redacted] was notified of the deficient practice at the Life Safety Code exit conference at 2:00 PM.	K 361	Failure of K361 SS=F Corridors - Areas Open to Corridor CFR(s): NFPA 101 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. The facility will put measures in place to ensure that on floors two and three of Rose Court building, which contains a family kitchen, activity room, library/living room that is open to the corridor, automatic smoke detection will be obtained. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. NJ Ex Order 26.4 [redacted] our fire alarm vendor, has been scheduled to complete the installation of automatic smoke detection devices in the identified areas and will complete a full audit of the facility to ensure no other locations are needed. 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. The administrator or designee has provided education to the maintenance and SES departments on campus regarding areas open to corridor spaces and standards related to automatic smoke	

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K 361	Continued From page 13 N.J.A.C 8:39-31.2(e)	K 361	detection devices 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS or designee will audit the findings of the fire alarm vendor. The findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review until substantial compliance is met. Any concerns will be reported and addressed promptly. 5. Date of completion: 10/28/2024	
K 374 SS=F	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 by: Based on observations and interview on 09/13/2024 in the presence of the [redacted], [redacted] and [redacted]), it	K 374	Failure of K374 SS=F Subdivision of Building Spaces - Smoke Barrier Doors CFR(s): NFPA 101 1. What Corrective Action will be taken	10/15/24

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K 374	Continued From page 14 was determined that the facility failed to ensure that penetrations through smoke/fire barriers were protected by a system or materials capable of restricting the transfer of smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5, NFPA 105, and NFPA 80:2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:46 AM, revealed that the elevator lobby smoke/fire barrier doors on floor 2 of Rose Court had a 5/8-inch space between the meeting edges of the doors. In an interview at the time, the [U.S. FOIA] confirmed the observation. The facility's [U.S. FOIA] was notified of the deficient practice at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 105,80	K 374	for those residents found to have been affected by the deficient practice? a. The facility□s contracted door repair vendor, [NJ Ex Order 26.4(b)], has adjusted the elevator lobby smoke/ fire barrier doors on floor two of Rose Court to reduce the 5/8-inch space to within approved tolerances, and installed an astragal to eliminate any remaining space. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. The FMS and MS have audited all other fire doors to confirm they close within approved tolerances. 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. The administrator or designee has provided education to the maintenance and SES departments on campus regarding spacing and tolerances on all fire doors. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The correct spacing of all fire doors will be verified during monthly fire door inspections by the designated SES officer. b. The MS will audit the binder containing records of inspection monthly for one year for documentation of completed inspections. Any concerns found will be addressed promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review,	

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K 374	Continued From page 15	K 374	additional audits, education and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/24	
K 521 SS=F	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 and interviews on 09/13/2024 in the presence of the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that resident bathrooms were provided with ventilation in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations between 9:45 AM and 12:25 PM, revealed that the bathroom ventilation in rooms NJ Ex Order 26.4 [redacted], NJ Ex Order 26.4 [redacted], NJ Ex Order 26.4 [redacted], NJ Ex Order 26.4 [redacted] and NJ Ex Order 2 [redacted] were not functioning when tested by the U.S. FOIA (b [redacted]	K 521	Failure of K521 SS=F HVAC, CFR(s): NFPA 101 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. Building exhaust system was confirmed powered on and functioning in identified resident rooms which included NJ Ex Order 26.4 [redacted], NJ Ex Order 26.4([redacted], NJ Ex Order 26.4 [redacted], NJ Ex Order 26.4 [redacted], and NJ Ex Order 26 [redacted] A mechanical contractor and professional air balancing company have been consulted to ensure CFM of the bathroom ventilation system are functioning properly in the identified resident rooms. 2. How other residents with the potential to be affected by the same deficient practice will be identified?	10/28/24

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K 521	Continued From page 16 In interviews at the time, the U.S. FOIA confirmed the observations. The facility's U.S. FOIA was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 90 A	K 521	a. A mechanical contractor and professional air balancing company have been contracted to assess and report on the CFM of the ventilation system in all resident rooms within the facility. 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. The administrator manager or designee has provided education to the maintenance department on the HVAC units and standard CFM needed throughout the facility. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS or designee will complete monthly audits of 10% of resident rooms HVAC CFM output monthly for one year. Any concerns found will be addressed promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/28/2024	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated	K 531		10/15/24

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K 531	Continued From page 17 monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and interviews on 09/12/2024 and 09/13/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to produce a certificate of continued occupancy/compliance for 1 of 4 elevators in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Documentation review and interviews on 09/12/2024 and 9/13/2024 revealed that the annual inspection for Device 01-01 had a temporary certificate of occupancy/compliance stating that the conditions of the attached inspection report must be met no later than 06/22/2023. There was no inspection report attached	K 531	Failure of K531 SS=F Elevators, CFR(s): NFPA 101 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. Community contracted elevator vendor, OTIS, has been contacted to expedite repairs on device 01-01 to obtain certificate of occupancy/compliance. The repair work order will be filed with the expired temporary certificate and the vendor will provide a current certificate of continued occupancy upon completion. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. The FMS, MS, and SES audited and confirmed all other devices/cars have a current certificate of occupancies and do not have any expired temporary certificates. 3. What measures will be put into place or what systemic changes will be made to	

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K 531	Continued From page 18 indicating which violations should require correction and there was no documentation regarding the correction of the violations. In an interview at 3:00 PM, the surveyor requested for the U.S. FOIA to provide any additional information regarding the elevator inspections for review the following morning. No further documentation was provided. The facility's U.S. FOIA was notified of the deficient practices at the Life Safety Code exit conference on 09/13/2024 at 2:00 PM. N.J.A.C 8:39-31.2(e) ASME A 17.1/CSA B44	K 531	ensure that the deficient practice does not recur? a. The administrator or designee has provided education to the maintenance department and SES on campus regarding temporary certificate expirations and certificate of occupancy needs in relation to elevator standards. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS or designee will audit the binder containing records of inspection monthly for one year for documentation of completed inspections and current certificates. Any concerns found will be addressed promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/2024	
K 541 SS=F	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including	K 541		10/15/24

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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) COMPLETION DATE
K 541	Continued From page 19 pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 09/13/2024 in the presence of the [redacted], it was determined that the facility failed to ensure that all laundry chute intake doors were self-closing and positive latching. The facility also failed to ensure that the bottom of the waste chute was protected by an approved automatic closing or self-closing door in accordance with NFPA 101:2012 Edition, Sections 9.5,9.5.2, and NFPA 82, Sections 5.2.3.2.2, 5.2.3.3.2.1 This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 10:02 AM and 12:05 PM, revealed that the linen chute doors on floors 2 and 3 of the Rose Court building did not positive latch when tested by the [redacted] An observation at 11:20 AM, revealed that the bottom of the laundry chute on the Evergreen wing was not provided with an automatic closing door because the magnetic hold open device was	K 541	Failure K541 SS=F Rubbish Chutes, Incinerators, and Laundry Chutes, CFR(s): NFPA 101 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. The latches of the Rose Court floor two and three linen chute doors were reinstalled by the Maintenance Supervisor and now positively latch. b. The community contracted door repair vendor, [redacted], re-enabled the magnetic hold-open device for the door at the bottom of the Evergreen laundry chute, enabling the automatic door closing function. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. The FMS and MS have audited all other linen chute door latches and automatic closing door functions. Any deficiencies found were promptly corrected.	

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 _____	**09/13/2024**

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
K 541	Continued From page 20 not functioning. During interviews at the time, the [U.S. FOIA] confirmed the observations. The facility's [U.S. FOIA] was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 82	K 541	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. The administrator or designee has provided education to the maintenance department regarding rubbish and laundry chutes within the facility in relation to defined standards 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The MS or designee will complete monthly audits of all automatic closing doors and chutes to ensure positive latches for one year. Any concerns found will be addressed promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/15/24	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on	K 911	Failure of K911 SS=F Electrical Systems	10/28/24

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 _____	**09/13/2024**

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
K 911	Continued From page 21 09/13/2024 in the presence of the U.S. FOIA (b) (6) [redacted]), U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the emergency backup generator was provided with a remote manual stop station in accordance with NFPA 101:2012 Edition, Sections 9.1.3.1 and NFPA 110:2010 Edition, Sections 5.6.5.6 and 5.6.5.6.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:12 PM, revealed that the emergency backup generator was not provide with a remote manual stop station to stop the prime mover for an emergency shutdown. In an interview at the time, the U.S. FOIA [redacted] confirmed the observation. The facility's U.S. FOIA [redacted] was notified of the deficient practices at the Life Safety Code exit conference at 2:00 PM. N.J.A.C 8:39-31.2(e) NFPA 110	K 911	- Other CFR(s): NFPA 101 1. What Corrective Action will be taken for those residents found to have been affected by the deficient practice? a. A remote manual stop for the emergency backup generator is scheduled for installation by the community contracted vendor on or before 10/15/24. 2. How other residents with the potential to be affected by the same deficient practice will be identified? a. Any new emergency backup generators being installed or replaced will be installed with a remote manual stop to ensure standard compliance. 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. The administrator or designee has provided education to the maintenance and SES departments on campus regarding the remote manual stop for the emergency backup generator. 4. How the Corrective action will be monitored to ensure the deficient practice is being corrected and will not recur? a. The presence and accessibility of the remote manual stop will be verified during monthly fire drills performed by a designated SES officer b. The MS will audit the binder containing records of inspection monthly for one year for documentation of completed inspections. Any concerns found will be addressed promptly. Audit findings will be reported to the Quality Assurance/Performance Improvement	

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 _____	**09/13/2024**

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
K 911	Continued From page 22	K 911	Committee (QAPI) monthly for review, additional audits and corrective actions may be determined based on audit findings. 5. Date of completion: 10/28/24	

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 01 - MAIN B. Wing Y2	11/1/2024 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0223	10/15/2024	LSC K0293	10/15/2024	LSC K0321	10/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	10/31/2024	LSC K0345	10/28/2024	LSC K0351	10/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0361	10/28/2024	LSC K0374	10/15/2024	LSC K0521	10/28/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	10/15/2024	LSC K0541	10/15/2024	LSC K0911	10/28/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
9/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO