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	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cedar Crest/Mountainview Gardens	4 Cedar Crest Village Drive Pompton Plains, NJ 07444

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45622 Complaint #: NJ184124 Based on interviews, record review, and review of other pertinent facility documentation on [DATE] and [DATE], it was determined that the facility failed to follow a resident's (Resident #2) wishes for a Do Not Resuscitate (DNR) status who had a signed Physician's Order (PO) and a Practitioner Orders for Life-Sustainable Treatment (POLST) in their chart when the resident experienced a cardiac arrest on [DATE]. This deficient practice was identified for one resident (Resident #2), and is evidenced by the following: According to the Admission Record, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: Dementia (memory loss), Hypertension (a condition in which blood in the artery wall is too high) and Muscle Weakness. A review of the admission Minimum Data Set, an assessment tool used to facilitate the management of care dated [DATE], reflected that the resident had a Brief Interview for Mental Status score of 10 out of 15, indicating that the resident's cognition was moderately impaired. According to the Facility Reportable Events (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated [DATE], with an event date of [DATE] and a time of event of 8:20 P.M., revealed the following for Resident #2: on [DATE], at approximately 8:10 P.M., Resident #2 had a witnessed cardiac arrest while in bed. Chest compressions were initiated following confirmation of cardiac arrest by Licensed Practical Nurse (LPN). At 8:20 P.M., chest compressions were discontinued and resident #2 was pronounced dead by the Nursing Supervisor. A review of the Resident's Order Summary Form (OSF) with an order initiated on [DATE] with a Code B status (DNR) and a signed DNR form by Resident #2 and their physician on [DATE]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:39 P.M. during an interview with the Licensed Practical Nurse, (LPN) she stated, I was called by the primary nurse/ Registered Nurse (RN) caring for the resident (Resident #2) who stated there was something going on with Resident #2. I got to the room and observed Resident #2 with oxygen in place, head of bed elevated and pale. I called the resident by their name, but he/she was not responding. I than tried to call the RN who had gone out to check the resident's code status. I flattened the resident's bed at which time the resident appeared not to be breathing, I began chest compression while still trying to confirm the resident's code status on the phone with the RN. Someone than said, the resident was a DNR, I'm not sure who it was, it was all happening so fast. Chest compression was done for approximately two minutes, it was so fast, and I don't recall the time, but it was not done for long (chest compression). During the same interview, the LPN stated, I did not verify the resident's code status prior to initiating chest compressing. I saw the resident not breathing and try to save them because I was thinking, if the resident was a Full Code, we need to save them. When asked if the facility's policy was followed, the LPN said, No, I should have verified the resident's code status prior to initiating chest compression. On [DATE] at 1:42 P.M. during an interview with the RN, she confirmed to be the primary nurse for Resident #2 on [DATE]. She stated the resident was noted with distress while doing a body assessment. I called the LPN for assistance while I went to get another oxygen concentrator, we were unsure of the resident's code status. While away from the room, the LPN asked me to check Resident #2's code status in the front of their chart. While at the front desk, the LPN had initiated chest compression. I communicated with the LPN and told her the resident was a DNR and chest compression should be stopped. Chest compression was probably performed for approximately two minutes. The RN/Supervisor came in and pronounced Resident #2 dead. When asked by the surveyor if the facility's policy was followed, the RN said No, if a resident is a DNR, we are not supposed to perform chest compression. She continued to state, if a resident is found unresponsive, the first thing to do is check the resident's code status and follow what the POLST says. On [DATE] at 2:16 P.M. during an interview with the Director of Nursing (DON) she stated the resident's code status is usually in the front of the resident's chart under the advance directive tab. Staff are aware to check the front of the chart to determine the status of the resident. She stated, her expectation is, once the nurse identifies an issue with the resident, a resident is found unresponsive, or in a medical emergency, the resident's code status should be determined prior to providing any form of treatment for the resident. When asked by the surveyor if the facility's policy was followed for Resident #2 on [DATE], she said, No, the policy was not followed. The nurse should have determined the resident's code status once cardiac arrest was identified prior to initiating Cardiopulmonary Resuscitation (CPR) for Resident #2. A review of the facility's policy with a revision date of ,d+[DATE] titled Designation of Code Status under Purpose/Scope revealed: To maximize resident autonomy by discussing and documenting resident choices regarding life sustaining and end of life choices. Under Policy revealed: A designated code status and accompany physician order, helps the staff to understand and adhere to a resident's wishes regarding life sustaining treatment. The physician's order is the source document that drives the care of the resident. The code designation will be decided by the resident, or their legal surrogate decision maker, in consultation with the primary care provider. N.J.A.C 8:,d+[DATE].6 (g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 45622 Complaint #: NJ184124 Based on interviews, record review, and review of other pertinent facility documentation on 03/11/2025 and 03/12/2025, it was determined that the facility failed to completely fill out a Medical Record (MR) which contained the New Jersey Universal Transfer Form (NJUTF) for a resident (Resident #2) who was sent out to the Hospital. This deficient practice was identified for one resident (Resident #2), and was evidenced by the following: According to the Admission Record, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: Dementia (memory loss), Hypertension (a condition in which blood in the artery wall is too high) and Muscle Weakness. A review of the Resident #2's Progress Notes (PN) revealed that on 02/21/2025 at 4:01 P.M., the Registered Nurse (RN) documented that Resident #2 needed to be sent out to the emergency room (ER) for tachycardia, nauseous, and complain of weakness. A review of Resident #2's MR revealed the NJUTF for the 02/21/2025 transfer to the ER was not filled out completely. During an interview with the surveyor on 03/12/25 at 2:00 P.M., the Director of Nursing (DON) stated the transfer form should be entirely filled out by the nurse prior to sending the resident out to the hospital. When presented with Resident #2's transfer form, the DON confirmed the form was not filled out completely, and it should have been completed prior to sending out the resident (Resident #2). A review of the facility's policy dated 6/2021 titled, Universal Transfer Form (New Jersey). Revealed under Policy A Universal Transfer form will be completed, including all required attachments and accompany each resident who transferred or discharged from Continuing Care. NJAC 8:39-35.2 (d) 12