

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315491	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/23/2025
NAME OF PROVIDER OR SUPPLIER Cedar Crest/Mountainview Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Complaint #: NJ185754 Based on interviews, medical record review, and review of pertinent facility documents on 9/18/2025, it was determined that the facility failed to implement their abuse policy and procedure to ensure all residents were protected from abuse when a Dining Associate (DA #1) alleged a Certified Nursing Aide (CNA #1) physically abused a cognitively impaired resident (Resident #1) and did not immediately report the allegation and CNA #1 continued to provide resident care without a thorough investigation. This deficient practice was identified for 1 of 5 residents reviewed for abuse (Resident #1). On 4/19/2025 at approximately 4:45 PM, DA #1 alleged observing CNA #1 feed Resident #1 in the dining room. DA #1 alleged that Resident #1 was saying that the soup was too hot, and put their hands up, while CNA #1 pushed the resident's hands down, grabbed their arm, and manipulated the resident's arm to make a gripping motion. DA #1 did not report the incident until 4/22/2025, three days later, and CNA #1 continued to work three shifts, which gave her access to Resident #1 as well as other residents, until 4/22/2025, when the incident was reported to Administration and CNA #1 was suspended pending investigation. The facility's failure to implement their abuse policy including protecting Resident #1 as well as all residents from abuse by removing CNA #1 from resident care pending a thorough investigation placed all residents at risk for abuse. This posed a likelihood of serious physical and psychological harm, injury, or impairment which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 4/19/2025 at approximately 4:45 PM, after DA #1 witnessed CNA #1 allegedly abuse Resident #1, and did not immediately report it so CNA #1 continued to work having access to Resident #1 as well as other residents. The facility Administration was notified of the IJ on 9/18/2025 at 4:00 PM. The facility submitted an acceptable Removal Plan (RP) on 9/19/2025 at 3:08 PM. The surveyor verified the implementation of the RP during the on-site survey on 9/23/2025 at 11:45 AM. The evidence was as follows: A review of the facility's Abuse Prevention policy dated 5/2021, included: All employees are required to immediately report suspected or alleged incidents of apparent abuse, neglect, exploitation or mistreatment. Residents will be protected from contact with anyone implicated in an incident of suspected or alleged abuse and neglect until the investigation is completed. A review of facility's Abuse Reporting & Investigation policy dated 05/2021, included: Allegations involving abuse, neglect, exploitation or mistreatment are reported immediately, but not later than two hours after the allegation is made to the administrator of the facility and other officials (including the State Survey Agency and Adult Protective Services where state law provides jurisdiction in long-term care facilities). On 9/18/2025 at 9:45 AM, the facility provided a copy of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) dated 4/22/2025, with an event date 4/19/2025. The FRE included that DA #1 reported observing [CNA #1] feeding [Resident #1] soup that she believed was too hot. DA #1 reported that the resident was saying that the food was too hot, but [CNA #1] continued to attempt to feed [the resident]. DA #1 also reported that she observed [CNA #1] manipulating [Resident #1's] arm and made a gripping motion. A review of the investigation dated 4/22/2025, for the incident that occurred on 4/19/2025, revealed that CNA #1 was interviewed on 4/22/2025. CNA #1 stated that Resident #1 will often state that food is hot as a way to communicate that [the resident] is done eating rather than the food is actually too hot. When asked what CNA #1 does if it happens, CNA #1 reported that she stops feeding [the resident]. CNA #1 reported she will hold [Resident #1's] hand to comfort them while eating. The surveyor reviewed the medical record for Resident #1. According to the Face Sheet (an admission summary), Resident #1 was admitted to the facility with diagnoses which include but were not limited to: Alzheimer's disease, chronic kidney disease (kidneys are damaged and cannot filter your blood properly to remove waste), and diabetes. According to the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 7/31/2025, Resident #1 had short and long-term memory problems with severely impaired cognitive skills. A further review revealed for Functional Abilities, that the resident was dependent (a helper does all the effort) for eating (the ability to use suitable items to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident). A review of Resident #1's Holistic Care Plan dated assessment 7/30/2025, included an undated focus area for dining and eating, swallowing, nutritional status, oral and dental. The care plan approaches included: encourage resident to be as independent with dining as possible and assist as needed; notify nurse if resident refuses to eat meals; prefers to eat breakfast in room; encourage by mouth intake for adequate nutrition and hydration; give frequent queuing at times, assist one person to eat meals; and health shake supplements. The care plan did not include prior to the incident on 4/19/2025, that the resident says too hot</p>		