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	01/07/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint # 2705112, 2704904 Based on interviews, medical record reviews, and review of other pertinent facility documentation on 1/7/26, it was determined that the facility failed to implement a two -person assistant when transferring Resident #1 from bed to wheelchair in accordance with the resident's care plan. This contributed to the resident exhibiting signs of pain by grimacing, after the inappropriate transfer of the resident from bed to wheelchair by their Certified Nursing Assistant (CNA#1). Further facility assessment of Resident #1 through X-ray report, revealed that the resident sustained right femoral neck fracture (hip fracture). This deficient practice was identified for 1 of 4 residents reviewed (Resident#1).The evident is as followed: On 1/7/26, a review of the Face Sheet (FS), revealed that Resident #1 was admitted to the facility with a diagnoses that included but not limited to; Parkinson's disease, Alzheimer's disease, abnormalities of gait and mobility, muscle weakness and lack of coordination.On 1/7/26, a review of the Minimum Data Set (MDS), an assessment tool dated 10/23/25 revealed that the resident Brief Interview Mental Status (BIMS) was blank indicting that resident's cognition was poor.On 1/7/26, a review of Resident#1's care plan included a focus area addressing transfers. The care plan indicated that the resident required assistance with transfers. Further review revealed that the care plan was revised on 10/28/25, at which time it documented that the resident required a sit -to -stand lift for transfer with the assistance of two staff members.On 1/7/26, a review of clinical note dated 10/1/25 at 10:47AM, revealed that Resident #1 required total assistance of 2 persons for transferring using sit - to - stand lift.On 1/7/26, a review of a clinical note dated 12/1/25 at 2:09PM, revealed that the resident required total assistance of 2 persons for transferring using sit - to - stand lift.On 1/7/26, a review of clinical note dated 12/24/25 at 3:07PM, revealed that Resident #1 exhibited nonverbal signs of pain, and that the resident was then evaluated by the physician who also ordered an x-ray of the resident's bilateral hips. The clinical note stated that staff provided pain management for the resident. Another clinical note dated12/25/25 at 6:24AM, stated that x-ray results concluded that the resident had a right femoral neck fracture (Leg fracture). The resident was then transferred to the hospital for further evaluation and treatment.On 1/7/26 a review of the radiology report dated 12/24/25 at 11:56PM, revealed that Resident #1 had an x-ray of bilateral hips and pelvis due to pain. The result of the x-ray indicated that the resident had an acute right femoral neck fracture (hip fracture) with mild displacement. The X-ray further stated that the resident's pelvis and hip were intact and that the bony structure appeared Osteopenic (weak bones).On 1/7/26 the surveyor reviewed the Facility Reportable event (FRE) record, completed by the facility and submitted to the Department of Health on December 30, 2025. The facility reported on their investigation that they interviewed the assigned Certified Nursing Assistant (CNA #1) who assisted the resident on 12/24/25, and confirmed that CNA#1 transferred the resident independently using stand-pivot technique and without help from another staff member as required by the resident's care plan. The facility further stated that they are unable to (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

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	01/07/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	determine the exact cause of Resident#1's fracture due to the resident's past medical history of osteoporosis but they concluded within their investigation that the assigned CNA did not follow the outlined plan of care, and that the facility reeducated all licensed staff on the care plan process and mechanical lift competencies.On 1/7/26 at 10:29AM, the surveyor conducted an interview with a CNA #2 who stated that all resident's Activity of Daily Living is located on care plan. The CNA further stated that the transfer status for residents are usually on the resident's care plans, and that the care plans are located in a binder in each resident's bedroom closet.On 1/7/26 at 10:47AM, the surveyor conducted an interview with the License Practical Nurse (LPN) who stated that each CNA was aware of the location of the care plan and care card for each resident. The LPN revealed that the care plans and care cards (an abbreviated tool that reflects resident's care plan) are located in the resident's bedroom closets. She further revealed that the expectation was that the CNAs are to check the care plan, or the care card before initiating care.On 1/7/26 at 1:00PM, the surveyor conducted an interview with the Physical Therapist (PT), who stated that the resident was discharged from PT on 7/8/24. PT further stated that the resident was transferring with a rolling walker with moderate to maximum assistance upon discharge. PT also stated that after discharge from PT, it was the responsibility of the nursing staff to determine the safest mode of transfer for each resident.On 1/7/26 at 1:23PM, the surveyor conducted an interview with the DON regarding Resident#1's fracture. DON revealed that during the facility's investigation, staff were interviewed, and it was determined that Resident #1 did not sustain any fall. The DON further stated that CNA #1, who transferred the resident using a stand and pivot technique did not follow the instructions on the resident's care plan, which required that Resident #1 be transferred with sit - to- stand lift with 2 staff assistance. DON stated that her expectation is for the CNAs to review the care plan prior to providing care.Review of the CNA's position descriptions stated that they would implement each resident's individualized care plan.A review of the facility's policy Care / Service Plans revealed under Procedure number 9, All interdisciplinary team members will document any updates/ changes on care plan copy in the guest/apartment/ designated accessible location and review update with designated care associate [CNA], services and treatments to be administered .