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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 34421 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 1/23/24, was discharged from the facility and according to the Discharge Return Anticipated MDS, an assessment tool used to facilitate the management of care, dated 6/27/24, the Type of Discharge was indicated as unplanned. A review of Resident # 113's progress notes dated 6/18/24, revealed the resident had a planned discharged to an Assisted Living (AL) facility. On 9/9/24 at 12:20 PM, the surveyor interviewed the MDS Coordinator, 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 Director of Nursing and Administrator. 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

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 44605 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 hospice resident and b.) clarify an oxygen 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 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 always in pain but varies on the pain scale. 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: Parkinson's disease, Peripheral autonomic neuropathy, and Chronic pain. A Significant Change Minimum Data Set ((MDS) an assessment tool used for the management of care) date 8/4/24, documented under Section O indicating the resident is on Hospice. In the Hospice section of the paper chart, the surveyor observed a paper titled, Supplemental Interdisciplinary Progress Note dated 8/1/24, with medication recommendations for: 1. Morphine sulfate 20 mg/ml - 5mg/0.25ml sublingual (SL) every (q) hour, per resident request (PRN) for repressions >22 and/or Heart Rate (HR) >100 or other signs and symptoms (s/s) of moderate to severe pain or respiratory distress. 2. Ativan 0.5 mg by mouth (PO)/SL q 4 hours, PRN for anxiety or terminal restlessness. The progress note was signed by the Licensed Practical Nurse (LPN #1) from Grace Hospice and was initialed by MB who is the Nurse Practitioner (NP#1) for Resident #67. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the August and September 2024 Physician Orders (PO) included a PO dated 11/21/23 that read, 1. Tylenol 325 milligram (mg), (2) TABLET oral by mouth every 6 hours as needed for Mild Pain (Pain Score 1-4), dated 6/27/24. Indication: low back pain for pain scale of 1-5. 2. baclofen 5 mg tablet (1 tab) Tablet Oral. Indication: muscle spasms. Morphine and Ativan 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 8/1/24, 8/2/24 and 8/23/24 the chart had been reviewed by the 11PM to 7AM nurse had completed a 24 hour chart review without ordering the Morphine and Ativan medications. A review of the Hospice Skilled Nursing Visit Note in the paper chart revealed on 8/7/24, 8/14/24, and 8/21/24 and 8/27/24, Registered Nurse (RN#1) for the Hospice assessed and completed the current pain management regiment for Resident #67 but did see the missing pain 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 Morphine or Ativan. Surveyor and LPN#2 reviewed the hospice paper progress note from 8/1/24, and LPN#1 confirmed Morphine and Ativan 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 3rd floor Clinical Manager (CM#1), who stated the process for carrying out medications for a hospice resident is the hospice nurse will write out medication recommendations, the resident's doctor or nurse practitioner will review and initial the hospice recommendation paper indicating to carry out the order, and the nurse will carry out the order. The CM#1 acknowledged the hospice paper was initialed by the NP#1 and the Morphine and Ativan 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 Hospice Nurse for Resident #67. The LPN#1 stated, they had written the recommendations for Ativan and Morphine 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 Assistant Licensed nursing Home Administrator (ALHNA) 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 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/6/24 at 12:59 PM, the survey team met with the ALHNA and Director of Nursing (DON) to review the above mentioned concerns. No comments made at that time. 37791 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 oxygen at 2.5 Liters Per Minute (LPM) via a nasal cannula. The oxygen tubing was labeled and dated 9/1/24. 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 hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), diastolic (congestive) heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), centrilobular emphysema (chronic lung disease that damages the upper lobes of the lungs), and hypertension (a condition in which the force of the blood against the artery walls is too high). A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 8/2/24, reflected that the resident's cognitive skills for daily decision-making score was 11 out of 15, which indicated the resident had moderately impaired cognition. A review of the September 2024 Physician Order Sheet (POS) revealed a Physician's Order (PO) dated 7/13/24, for Oxygen with humidification, oxygen (O2) at 2-3 liter via N/C (nasal Cannula) at bedtime (HS) to maintain O2 above 90%. A review of the August and September 2024 electronic Treatment Administration Record (ETAR) revealed an order dated 7/13/24, for oxygen with humidification to give oxygen at 2-3 liters at 2-3 liters via N/C at H.S. to maintain O2 above 90%. A further review of the ETAR revealed that Oxygen was signed as being administered during the 3-11 PM shift. A review of the comprehensive care plan revealed a care area dated 7/24/24 for Respiratory and Cardiac care with a goal that the resident won't have signs and symptoms of respiratory distress. The care plan indicated that the resident required oxygen therapy for shortness of breath and a cardiac approach that included the resident would need assistance in keeping oxygen and maintain the prescribed liters to be administered at all times. The care plan also revealed under method of administration that the resident will be receiving 2 -3 liters per minute as needed to maintain O2 saturation above 90%. On 9/6/24 at 9:20 AM, the surveyor and the Licensed Practical Nurse (LPN#3), reviewed Resident #3's order for oxygen. The LPN #3 acknowledged that the resident was receiving oxygen via a nasal cannula at 2-3 liters per minute. After reviewing the resident's oxygen order, LPN #3 stated that the order should have been clarified with the physician and that it should have been written for either 2 LPM or 3 LPM. On 9/06/24 at 1:00 PM, the surveyor presented the above concerns to the Assistant Licensed Nursing Home Administrator, and Director of Nursing. There was no additional information provided. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 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 Campus Executive Chef (CEC) 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 CEC 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. CEC not sure when the oven was last cleaned was last cleaned. 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 CEC 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 Director of Nursing (DON) 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 Assistant Licensed Nurse Home Administrator (ALNHA) and Director of Nursing (DON) to review concerns. The ALNHA and DON had no comments for the above mentioned concerns. NJAC 8:39-17.2(g)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36419 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 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 Certified Nursing Assistant (CNA) on the Terrace Unit, exited room [ROOM NUMBER] wearing a pair of gloves. The surveyor observed signage outside room [ROOM NUMBER] which indicated the resident in room [ROOM NUMBER] was on Enhanced Barrier Precautions (EBP) which included: everyone must clean their hands, including before entering and when leaving the room; wear gloves and a gown 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 a dressing. The surveyor observed the CNA went directly from room [ROOM NUMBER] into room [ROOM NUMBER], 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 CNA exited room [ROOM NUMBER], walked down the hallway to the nurses' station, requested assistance from the Licensed Practical Nurse (LPN) on the floor and re-entered room [ROOM NUMBER] 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 Terrace Unit. The surveyor observed the CNA entered the communal dining room and obtained a tray, delivered the tray to room [ROOM NUMBER] 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 [ROOM NUMBER] was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/24 at 12:32 PM, the surveyor discussed the above observations and concerns with the CNA. The CNA acknowledged that she should have changed her gloves and performed hand hygiene between residents. The CNA further stated that she had not been in serviced on EBP and was not aware she should have performed hand hygiene when entering and exiting the rooms of residents who are on EBP. On 9/9/24 at 12:01 PM, the surveyor interviewed the Acting Unit Manager for the Terrace 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 EBP policy which included everyone must perform hand hygiene before entering and exiting rooms. On 9/9/24 at 12:15 PM, the surveyor discussed the above observations and concerns with the Director of Nursing (DON) 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 EBP. 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 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)