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	01/29/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to keep the call bell soft pad within residents' reach. This deficient practice was identified for 2 of 22 residents reviewed for accommodation of needs (Resident #57 and #112), and was evidenced by the following: 1. On 01/22/2026 at 11:40 AM, the surveyor observed Resident #57 in their room, with eyes closed, seated in a wheelchair in front of the sink. The surveyor observed that the call bell soft -touch pad (a device used to summon the staff for assistance) was on the bedside table, not within the resident's reach. On 1/23/26 at 9:35 AM, the surveyor observed Resident #57 in their room, with eyes closed, seated in a wheelchair in front of the sink. The surveyor observed that the call bell soft -touch pad was on the bedside table, not within Resident #57's reach. The surveyor reviewed the medical record for Resident #57. A review of the admission Record reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to; Alzheimer's Disease (a progressive brain disease causing dementia), diabetes mellitus (a disease of inadequate blood levels of glucose), and chronic kidney disease (a long-term condition where the kidneys are damaged and lose their ability to filter waste and excess fluid from the blood over time.) A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 10/27/25, indicated that Resident #57's cognitive skills for daily decision-making were severely impaired. The MDS further indicated that the resident was dependent on staff for activities of daily living care and received hospice services. A review of the Resident's Holistic Care Plan (CP) for Falls included care plan approaches to address risks, which indicated to provide the resident with a flat sensory soft-touch call bell for easy access to call for assistance and to encourage the resident to use it. 2. On 1/22/26 at 12:28 PM, the surveyor observed Resident #112 in their room, in bed watching television. The surveyor observed that the call bell soft-touch pad was hanging off the bedside railing, not within the resident's reach. The surveyor reviewed the medical record for Resident #112 (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission Record reflected that the resident was admitted to the facility on [DATE] with diagnoses that included but were not limited to; Alzheimer's Disease, Contracture of Right hand (a debilitating condition characterized by the stiffening and tightening of tissues, leading to reduced mobility and function), and Anxiety (feeling of worry, nervousness, or unease about something with an uncertain outcome.). A review of the Quarterly MDS, dated [DATE], indicated that Resident #112's cognitive skills for daily decision-making were severely impaired. The MDS further indicated that the resident needed moderate assistance from staff for activities of daily living care as well as having impairments of upper extremities. A review of the Resident's Holistic CP for Falls included care plan approaches to address risks, which indicated to provide a flat call bell. On 1/23/26 at11:20 AM, in the presence of the 3rd floor Unit Manager/Registered Nurse (UMRN#1), the surveyor observed Resident #112 call bell was hanging off the resident's bed, not within the resident's reach. The UMRN#1 stated the call bell needs to be within reach of the resident for safety. On 1/23/26 at 11:50 AM, the Director of Nursing (DON) provided the surveyor with a facility policy titled, Call Bell System Response with a revised date of 5/2021. The procedure section of the policy revealed, 1. Each guest/resident may activate the Call Bell System to contact Continuing Care Staff for their individualized needs by activating their call button or pull cord located within their individual suite and as designated within the Continuing Care neighborhood. On 1/28/26 at 12:33 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and DON to review concerns found during the survey. The DON stated the call bells need to be within reach of the resident. On 1/29/26 at 12:21 PM, the surveyor met with the LHNA and DON for the exit conference, no further pertinent information provided. NJAC 8:39- 27.1(a); 31.8 (c)(9)

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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. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to follow appropriate hand hygiene practices during dining observations in 1 of 3 dining rooms (2nd floor) and for 2 of 3 staff members (Certified Nursing Assistant (CNA)) and Registered Nurse (RN) during meal service. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24, 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 .After touching a patient or the patient's immediate environmentAfter contact with blood, body fluids, or contaminated surfacesImmediately after glove removal. On 01/23/2026 at 9:45 AM, the surveyor observed meal service in the 2nd-floor dining room and observed the following: On 1/23/26 at 9:45 AM, the RN entered the dining room and assisted Resident #5 with their meal. The surveyor observed that the RN fed the resident and then, with no observed hand hygiene, went to assist Resident #87. The RN with no observed hand hygiene went back to feed Resident #5. On 1/23/26 at 10:10 AM, the surveyor observed the CNA in the 2nd-floor dining room assisted residents with meal service. After the CNA assisted an unsampled resident, the surveyor observed the CNA wet her hands and immediately placed them under the stream of water without applying soap or lathering outside of the water. On 1/23/26 at 10:12 AM, the surveyor observed that after the CNA assisted an unsampled resident with their meal, the CNA applied soap to her hands and immediately placed them under a running stream of water without lathering outside for 20 seconds. On 1/23/26 at 10:20 AM, the surveyor observed the CNA assisted an unsampled resident with their meal. The CNA applied soap to her hands, lathered for 5 seconds outside the stream of water, then placed them under the stream. On 1/23/26 at 10:30 AM, the surveyor asked the CNA about the facility's hand hygiene policy. The CNA replied that she should wet her hands, apply soap, and lather them under running water for 20 seconds. The surveyor asked the CNA who had taught her to lather with soap under a stream of water. The CNA replied to the surveyor that the Infection Preventionist or the Educator. At that time, the CNA stated that she had been mistaken and confirmed that she had been instructed to lather her hands for 20 seconds outside the stream of water, and that she should have washed her hands in accordance with the facility policy. A review of the CNA's Hand Hygiene Competency dated 8/21/25 reflected the CNA passed the competency, which included . scrubbing all surfaces of hands for at least 20 seconds .then rinsing hands under clean, running water and avoiding recontamination . On 1/23/26 at 10:35 AM, during an interview with the surveyor, the RN stated that she received hand hygiene in services yearly and that her last in-service was a year ago. The surveyor asked the RN whether she should perform hand hygiene between residents when assisting with meal service. The RN replied that she was in-service, that she only needed to perform hand hygiene before she entered the dining room, and then after assisting all of the residents, she should wash her hands before she left the dining room. The RN stated that hand hygiene before and after assisting with meals was not important. A review of the RN's Hand Hygiene Competency dated 8/21/25 reflected the RN passed the competency, which included .Perform hand hygiene immediately before, between, and after physical contact with a resident .Handwashing is required anytime you are handling food . On 1/28/26 at 9:24 AM, during an interview with the surveyor, the Infection Prevention Nurse (IPN) confirmed that she and the educator had provided hand hygiene in-services to the staff and that all staff were instructed to wet their hands, apply soap and lather outside the stream of water for at least 20 seconds before putting their hands under the water. She also confirmed that the staff should perform hand hygiene before and after assisting each resident with meal service. On 1/28/26 at 12:33 PM, the survey team met with the License Nursing Home Administrator and Director of Nursing to discuss the above observations and concerns. A review of the facility's policy, Hand Hygiene -Standard Operating Procedure dated 3/24 and reviewed annually, reflected.Purpose.To prevent the spread of potentially infectious (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	organisms to residents/patients, staff and visitors.Procedure.When to perform some form of hand hygiene (at minimum) .Immediately before, between and after physical contact with a resident/patient.Hand washing is required anytime you are handling food. Procedure/Technique.Wet hands with clean running water.Apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers, rinse hands with clean water, use disposable towels to dry hands, use a different disposable towel to turn off the faucet. On 1/29/26 at 12:21 PM, no further information was provided. NJAC 8:39-27.1 (a)