STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING ______ B. WING ______	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

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F 000	INITIAL COMMENTS Survey Date: 4/19/22 Census: 165 Sample: 36 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to act upon the Wound Doctor (WD) treatment recommendations according to professional standards of clinical practice for 2 of 2 residents reviewed for pressure ulcers, Resident #15 and #85.	F 686	1.The identified licensed nurse was re-educated on following the Ex.Order 26.4(b)(1) company recommendations. Resident #15, physician was notified, and this resident has no negative outcome related to this deficient practice.	5/3/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/03/2022

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.

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F 686	Continued From page 1 The deficient practice was evidenced by the following: 1. On 4/8/22 at 11:00 AM, the surveyor interviewed Resident #15 who stated, "EXX Order 26 [redacted]" The resident was receiving wound treatment daily. The surveyor reviewed Resident #15's hybrid (paper and electronic) medical records that revealed the following: According to the Admission Record, Resident #15 had diagnoses that included but were not limited to EX Order 26 § 4b1 EX Order 26 § 4b1 [redacted] The Admission Minimum Data Set (MDS) an assessment tool dated 1/6/22, revealed a Brief Interview for Mental Status (BIMS) score of EX Or which indicated that EX Order 26 § 4b1. The MDS also reflected that the resident was at EX Orde [redacted]. The resident currently had a EX Order 26 § 4b1. The WD's Visit Reports dated 3/1/22, 3/8/22, 3/15/22, 3/22/22, and 4/6/22 indicated a EX Order 26 § 4b1 [redacted] daily). The March and April 2022 Order Summary Report (OSR), reflected an order to cleanse the EX Order 26 § 4b1 [redacted]	F 686	Resident #85, physician was notified, and this resident has no negative outcome related to this deficient practice. 2. An audit was completed on residents who are evaluated by the Ex.Order 26.4(b)(1) company to ensure there was no discrepancy with the Ex.Order 26.4(b)(1) treatment and the Ex.Order 26.4(b)(1) company□s recommendations. None were found. 3.Licensed nurses were re-educated by the Director of Nursing on following the wound care recommendations. The Unit Manager or designee will review all recommendations on a monthly basis from the Ex.Order 26.4(b)(1) e company to ensure the treatment on the E-Tar are transcribed accurately. 4.The Director of Nursing or designees will review monthly 10% of the recommendations of the Ex.Order 26.4(b)(1) company to ensure the consults are transcribed accurately. The DON/designee will report of the results of the audit and any corrective action taken at the monthly QAA committee meeting for 2 consecutive quarters.	

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F 686	Continued From page 2 EX Order 26 § 4b1 every day. The WD Visit Report recommendations and the 3/29/22 Wound Description form indicated to Ex.Order 26.4(b)(1), However, the treatment recommendation was not transcribed to the Electronic Medical Record (EMR) and the electronic Treatment Administration Record (eTAR). On 4/8/22 at 1:25 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that she was unaware of the Ex.Order 26.4(b order of BID by the WD because the Licensed Practical Nurse/EX Order 26 § 4 Nurse (LPN/WN) would enter and update the treatment orders. The RN/UM acknowledged that the WD's treatment recommendation should have been transcribed in the eTAR. On 4/11/22 at 9:45 AM, the surveyor conducted a phone interview with the LPN/WN in the presence of the RN/UM. The LPN/WN stated that he made wound rounds with the WD weekly, and the WD would communicate the EX Order 26 § 4b1 order to him during rounds and email the report afterward. He would then transcribe the new Ex.Order 26.4(b into the EMR and transcribed it to the eTAR. At that time, the surveyor asked the LPN/WN to explain why the March and April 2022 OSR reflected an order for Ex.Order 26.4(b)(1) and dressing to the EX Order 26 § 4b once daily instead of twice daily as recommended by the WD. The LPN/WN stated that he was not aware of the EX Order 26 § EX Order 26 § 4b1 order and the WD recommendation discrepancy until the surveyor's inquiry. The LPN/WN further stated to the surveyor that he	F 686		

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F 686	Continued From page 3 should have clarified the wound treatment order to the doctor. 2. On 4/7/22 at 10:40 AM, the surveyor observed Resident #85 in bed lying on an mattress. The surveyor reviewed the medical record for Resident #85 which revealed the following: According to the physician's progress notes dated 3/23/22, Resident #85 had a diagnosis that included a History of EX Order 26 § 4b1 The Significant Change in Status Assessment MDS (SCSA/MDS) dated 2/24/22, indicated a BIMS score of EX, which reflected that the resident's cognition was EX Order 26 § 4b1. The SCSA/MDS indicated that the resident was determined to be at risk for EX Order 26 § 4b1 The WD Visit Report dated 3/15/22 indicated its wound treatment recommendation to EX Order 26 § 4b1 The WD visited the resident on 3/22/22 and updated the recommendation on the Visit Report to discontinue the treatment of EX Order 26 § 4b1 The WD Visit Report dated 3/29/22 and 4/6/22 indicated a recommendation to continue to	F 686		

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F 686	Continued From page 4 EX Order 26 § 4b1 The April 2022 OSR reflected physician's orders 'EX Order 26 § 4b1 On 4/11/22 at 1:00 PM, the License Practical Nurse Unit Manager (LPN/UM) informed the surveyor that the facility LPN/WN assisted the WD to do weekly wound assessments on residents. The LPN/UM stated that the LPN/WN would receive wound reports from the WD, which included Ex.Order 26.4(b)(1) recommendations. She further stated that the LPN/WN would transcribe the EX Order 26 § treatment recommendations into the eTAR. The LPN/UM acknowledged to the surveyor that the WD treatment recommendation on 4/6/22 was not transcribed to the EMR and the eTAR. On 4/13/22 at 10:25 AM, the surveyor interviewed the LPN/WN concerning the 4/6/22 WD's Visit Report recommendations. The LPN/WN informed the surveyor that he assisted the WD to "wound rounds" every Wednesday. The LPN/WN stated that the WD would later provide him with written reports that included EX Order 26 § 4b1 recommendations. He further stated that the resident's Medical Doctor (MD) told him to follow the WD recommendations. The surveyor further asked the LPN/WN if the WD recommendations were all followed, and he stated "no, it should have been followed." On 4/13/22 at 2:11 PM, the Administrator and	F 686		

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F 686	Continued From page 5 Director of Nursing met with the survey team. No further information was provided. A review of policy titled "Physician Services" revised 2022, did not indicate how the consultant's recommendations should be executed by the nursing staff. NJAC 8:39-11.2 (b)	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined the facility failed to ensure two residents were receiving Ex.Order 26.4(b)(1) as prescribed by the physician. This was found for 2 of 3 residents reviewed for EX Order 26 § 4b, Resident #53 and Resident #98, and was evidenced by the following: 1. On 04/07/22 at 10:32 AM, during the initial tour of the facility Resident #53 was out of the bed in a EX Order 26 § 4b1. The resident had EX Order 26 § 4b1 EX Order 26 § 4b1	F 695	Resident # 53, physician was notified, and this resident had no negative outcome related to this deficient practice. Resident # 98, physician was notified, and this resident had no negative outcome related to this deficient practice. 1. An audit was completed on all residents using Ex.Order 26.4(b)(1) to validate they were receiving Ex.Order 26.4(b)(1) as prescribed by the physician. All were found to be compliant. 2.Staff were re-educated by the	5/3/22

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F 695	Continued From page 6 concentrator (a medical device that provides Ex.Order 26.4(b)(1)). The resident's Ex.Order 26.4(b) was set on four liters of Ex.Order 26.4(b)(1 The surveyor reviewed the quarterly Minimum Data Set (MDS), an assessment tool dated 2/7/22. The MDS showed Resident #53 had a Brief Interview of Mental Status of EX O, meaning the resident had moderate EX Order 26 § 4b1. Under section O of the MDS, Special Procedures and Treatments, indicated that Resident #53 was EX Order 26 § 4b dependent. Medical diagnoses included, but not limited to EX Order 26 § 4b1 On 04/08/22 at 09:45 AM, the surveyor observed Resident #53 in the room sitting in the EX Order 26 § 4b1 . The resident was wearing the EX Order 26 § 4 On 04/11/22 09:50 AM, the surveyor observed Resident #53 in the room in a EX Order 26 § 4b1 . The EX Order 26 § 4b1 that was attached to the EX Order 26 § 4b The Ex.Order 26.4(b)(1) was set on Ex. On 04/11/22 at 10:33 AM, the surveyor reviewed the physician orders in the Electronic Medical Record (EMR) which showed the following order, administer EX Order 26 § 4b1 at Ex.Order 26.4(b continuously. On 04/11/22 at 10:42 AM, the surveyor reviewed the residents care plan which showed a EX Order 26 § 4b1	F 695	DON/designee on reviewing physicians order prior to administering supplemental Ex.Order 26.4(b) . UM/designee on daily rounds will check the Ex.Order 26.4(n concentrator to validate the resident is receiving the correct amount of Ex.Order 26.4(b) as prescribed by the physician. 3.DON/designee will conduct monthly audits of residents receiving Ex.Order 26.4(b) to validate they are receiving supplemental Ex.Order 26.4(b)(1 as prescribed by the physician. 4.The DON will report on the results of the audit monthly and corrective action will be reported to the QAA monthly committee meeting for 2 consecutive quarters.	

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F 695	Continued From page 7 EX Order 26 § 4b1 On 04/11/22 at 10:55 AM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1) who was assigned to Resident #53. The surveyor asked how much EX Order 26 § 4b the physician ordered for Resident #53 and LPN #1 said, "2 liters". At the same time, the surveyor asked the LPN #1 to go to the resident's room and check the EX Order 26 § 4b. LPN #1 along with the surveyor entered the resident's room and looked at the EX Order 26 § 4b which was set at Ex.Order 26.4(. LPN #1 said, "how did that get to four", and asked Resident #53 if they touched it. The resident said he/she would never touch something like that. LPN #1 could not speak to how the EX Order 26 § 4b was set on EX Order 26 § 4b1 instead of the ordered EX Order 26 § 4b1 and proceeded to lower it to EX Order 26 § 4b The surveyor asked if the staff should be checking the settings and LPN #1 said, "yes". On 04/14/2 at 10:12 AM, the surveyor reviewed the electronic Treatment Administration Record (eTAR) which showed the nursing staff signed administer EX Order 26 § 4b1 . This was signed by the nursing staff on day, evening, and night shifts daily for the month of April 2022. 2. On 4/7/22 at 12:29 PM, the surveyor observed Resident #98 in bed, alert and oriented. The resident was receiving EX Order 26 § 4b1 that was attached to an EX Order 26 § 4b1 The EX Order 26 § 4b1 was set at EX Order 26 § 4b1	F 695		

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F 695	Continued From page 8 On 4/11/22 at 9:10 AM, the surveyor observed Resident #98 in bed, receiving EX Order 26 § 4b1 . The EX Order 26 § 4b1 was set at EX Orde . The surveyor reviewed the EMR of Resident #98 which revealed the following: The resident's Admission Record revealed that Resident #98 was admitted with diagnoses that included EX Order 26 § 4b1 . The Quarterly MDS dated 3/8/22, indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored a EX Or out of 15 which indicated that the resident was EX Order 26 § 4b1 . The April 2022 Order Summary Report revealed a physician's order, dated 12/2/21, that read: "EX Order 26 § 4b1 The April 2022 eTAR was initialed by nurses every shift from 4/1/22 to 4/12/22 to indicate the setting for the EX Order 26 § 4b1 . A care plan with the focus "[The resident] has potential for EX Order 26 § 4b1	F 695		

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F 695	Continued From page 9 EX Order 26 § 4b1 ". Under Interventions, an intervention listed read EX Order 26 § 4b " The date the care plan was initiated was 12/8/21 and the revision date was 3/5/22. On 4/12/22 at 9:41 AM, the surveyor asked LPN #2, assigned to care for the resident, how many EX Order 2 the resident's EX Order 26 § 4b should be set at. LPN #2 said the resident wore EX Order 26 § 4b continuously, she reviewed the EX Order 26 § 4b1 On 4/12/22 at 9:56 AM, the surveyor entered the resident's room with LPN #2. The surveyor observed the Ex.Order 26.4(b)(1) r setting at 3 LPM. LPN #2 adjusted the setting to 2 LPM. LPN #2 said she checked the Ex.Order 26.4(b) setting in the morning, it was at 2 LPM and thought it may have been changed while the Certified Nursing Assistant (CNA) was providing care to the resident. On 4/12/22 at 10:00 AM, the surveyor asked the assigned CNA if she adjusted the Ex.Order 26.4(b) concentrator settings for Resident #98. The CNA said no. When asked if she had ever changed the EX Order 26 § 4b1 settings for a resident, the CNA said no, she would call the nurse to check it. On 4/12/22 at 10:18 AM, the surveyor spoke with the Nurse Supervisor (NS) of the unit and asked about the resident's EX Order 26 § 4b1. The NS stated during morning rounds of the unit at 8 AM, he checked the resident's EX Order 26 § 4b as part of his rounds, and he saw the EX Order 26 § 4b setting at EX Order 26 §. The surveyor asked when he became aware of the issue with the resident's EX Order 26 § 4b1 on the	F 695		

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F 695	Continued From page 10 EX Order 26 § 4b1 being different than what was ordered by the physician. The NS said LPN #2 just made him aware after the surveyor and LPN went into the resident's room. On 4/12/22 at 10:42 AM, the NS told the surveyor that the EX Order 26 § 4b1 setting was just re-checked, and the EX Order 26 § 4b1 was not at EX . The NS said they believed the EX Order 26 § 4b1 On 4/12/22 at 12:21 PM, the surveyor spoke with LPN #2 and asked when she first noticed the EX Order 26 § 4b settings were different than what was ordered by the physician. LPN #2 said since March. On 4/12/22 at 1:05 PM, the survey team met with the Administrator and the DON to discuss the concern of the resident not receiving EX Order 26 § 4b at the setting the physician ordered. The surveyor requested a copy of the facility's policy and procedures for EX Order 26 § 4b1 . On 4/13/22 at 11:40 AM, the surveyor asked Resident #98 if the resident knew what their EX Order 26 § 4b setting was. The resident replied, the staff said it should be set at two. The surveyor asked if the resident would ever adjust the EX Order 26 § 4b concentrator settings on their own. The resident said they would never touch the Ex.Order 26.4(b) machine or adjust the settings. On 4/13/22 at 1:10 PM, the DON provided the facility's policy and procedure titled "EX Order 26 § 4b " with a revision date of 4/2022, Under Policy, it read "EX Order 26 § 4b1	F 695		

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F 695	Continued From page 11 EX Order 26 § 4b1." Under Procedures 1 and 2 it read "EX Order 26 § 4b1 " EX Order 26 § 4b1 " The surveyor reviewed another policy titled, EX Order 26 § 4b1. The policy had a revision date of 2022. Under the procedure section it indicated that proper documentation on the Treatment Administration Record and Physician Order Sheet to ensure a current physician order. NJAC 8:39-27.1 (a)	F 695		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's documentation, it was determined that the facility failed to maintain a safe, functional and sanitary environment involving 2 of 34 resident room hand sinks (Rooms #150 and #152) The deficient practice was evidenced by the following: On 4/7/22 at 11:40 AM, the surveyor observed, during the initial tour, in room #150 the hand sink had a yellowish-brownish color pooling of water and a sign taped to the mirror above the sink with	F 921	1.Resident Room #150 and 152 hand sink was immediately repaired. All residents have the potential to be affected by this deficient practice. 2.All residents□ rooms hand sinks were checked and found to be in working order. 3. Staff was re-educated on utilizing the Maintenance Log record to fix any repairs	5/3/22

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F 921	Continued From page 12 the a message to not use the sink. On 4/11/22 at 10:30 AM, the surveyor observed, in room #150, the same sign taped to the mirror above the sink and the sink had yellowish-brownish water pooling in the sink. At 10:33 AM, the surveyor interviewed the certified nursing assistant (CNA) assigned to room #150 who informed the surveyor that the sink was clogged in both rooms #150 and #152 because the rooms shared a pipe for the sink in each room. The CNA stated that she filled the resident's basin with water at the sink to use for AM care and then disposed the water from the basin into the toilet in the bathrooms of room #150 and room #152. At 10:34 AM, the surveyor and the Licensed Practical Nurse (LPN) assigned to room #150 observed the water pooling in the sink. The LPN stated the sink had been clogged for a week or more and that the sink in room #152 shared the same pipe and was clogged too. The LPN stated she wrote a note in the Maintenance log book. The LPN and surveyor reviewed the Maintenance log book. There was a note dated 4/2/22 that informed the Maintenance Director of a clogged sink and initialed by an LPN and the LPN confirmed that it was her initials. There was no room number listed but the LPN confirmed the entry was for room #150. On 4/11/22 at 1:06 PM, the surveyor interviewed Maintenance Director (MD) in the presence of the Administrator and Director of Nursing. The surveyor asked the MD how often the Maintenance log book was checked. The MD responded that he checked it daily. He stated he	F 921	needed. The maintenance log record was updated. 4. The maintenance director will audit 10 sinks per month and report findings and any corrective actions to the monthly Quality Assurance Committee for two consecutive quarters.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING ______ B. WING ______	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 13	F 921		

was aware of the clogged sinks in rooms #150 and #152. He stated yes, that on 4/2/22 he "snaked" the pipe (a drain drilling tool but is nicknamed the snake due to its coiled shape). He further stated he saw that the water drained slowly because there was a clog further into the pipe that the "snake" couldn't go through and that it would require opening up the wall to fix it.

The MD stated that he checked the sink in room #150 every morning and had not seen any pooling of water. The surveyor informed the MD that both the LPN and surveyor observed the pooling of water at 10:30 AM. The surveyor asked if he had a plan to fix the problem and he stated he didn't know. The MD also stated he did not inform the Administrator of the problem.

On 4/12/22 at 10 AM, the Administrator provided a facility policy revised 2022 which indicated the following: Policy: "It is the policy to ensure all maintenance concerns/issues must be logged into the Maintenance Log Record in the maintenance communication book located on each nursing unit. The concerns/issues will be properly handled to assure resident and employee safety." And under Procedure #3 "The repairs are completed the day of request, if possible. If not possible, the repairs will be completed at the earliest possibility."

NJAC 8:39-31.4(a)

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062023	A. BUILDING: ______ B. WING ______	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, the facility failed to ensure staffing ratios were met for 14 of 14 day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" completed by the Licensed Nursing Home Administrator (LHNA) for the period of 3/20/22 through 4/2/22, revealed the staffing to resident ratios did not meet the minimum requirement of 1 Certified Nursing Assistant (CNA) to 8 residents for the day shift as documented below:	S 560	1, Corrective action(s)accomplished for resident(s)affected: No residents were identified to be affected by this deficient practice 2. Residents identified having the potential to be affected and corrective action taken: The deficient practice has the potential to affect all residents residing in the facility. 3. Measures will be put into place to ensure the deficient practice will not recur: The facility currently has 5 Nursing Agency contracts. Referral and sign on bonuses are offered. The call out Policy has been reviewed and the staff has been re-educated, Advertisements signs in the driveway leading up to the facility. The facility is recruiting on multiple employment search engines and multiple social media platforms. Depending on the needs of the day Nursing management to include Unit Mangers, Supervisors and ADON will be evaluated and received an assignment to assist with resident care. Rates have been increased for C.N. A.s. 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The DON/Designee will conduct weekly C.N.A. staffing schedule audits. The	5/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/03/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062023	A. BUILDING: ____ B. WING ____	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 03/20/22: 16 CNAs for 160 residents 03/21/22: 17 CNAs for 160 residents 03/22/22: 17 CNAs for 158 residents 03/23/22: 16 CNAs for 158 residents 03/24/22: 16 CNAs for 158 residents 03/25/22: 15 CNAs for 158 residents 03/26/22: 16 CNAs for 161 residents 03/27/22: 15 CNAs for 161 residents 03/28/22: 19 CNAs for 161 residents 03/29/22: 16 CNAs for 160 residents 03/30/22: 18 CNAs for 158 residents 03/31/22: 18 CNAs for 158 residents 04/01/22: 18 CNAs for 158 residents 04/02/22: 13 CNAs for 158 residents On 4/19/22 at 11:28 AM, the surveyor conducted an interview with the Staffing Coordinator (SC) via telephone. The SC acknowledged to the surveyor that she was aware of the new mandatory staffing ratio law. The SC also acknowledged that the facility did not meet the minimum staffing requirements and stated, "there were instances we ended up being short due to call out." She also informed the surveyor that the Administrator and the Director of Nursing were aware of the staffing insufficiency. No further information provided.	S 560	DON/Designee will report audit findings to the Administrator. The Administrator/Designee will analyze and trend findings and report outcomes at the monthly QAA Committee meeting, with follow up to recommendations, as necessary	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315283		5/31/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 05/03/2022	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 05/03/2022	ID Prefix F0921 Reg. # 483.90(i) LSC	Correction Completed 05/03/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
4/19/2022	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062023 Y1	A. Building B. Wing Y2	5/31/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/03/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING **01** B. WING ______	C **04/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE** **VAUXHALL, NJ 07088**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/19/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The Nursing Home is a 2-story building with a basement, that was built in 80's, It is composed of Type III protected. The facility is divided into 18-smoke zones. The generator does approximately 30% of the facility. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 05/03/2022

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING 01 B. WING ______	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 The facility has 185 certified beds. At the time of the survey the census was 160.	K 000		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483,	K 363		5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING 01 B. WING	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 363	Continued From page 2 and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/19/22, the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was observed in 1 of 50 resident room door's observed and was evidenced by the following: On 4/19/22, during the building tour from 9:00 AM to 3:30 PM, the surveyor and Maintenance Director, observed that the door to resident room #135 did not latch into the door frame. An interview was conducted with the Maintenance Director, who stated and confirmed that the above findings were observed. The Administrator was informed of the finding at the Life Safety Code exit conference. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	1. Resident # 135 had the potential to be affect and is stable. No other residents were identified having a negative impact from this deficient practice 2. All residents have the potential to be affect from this deficient practice. All residents□ doors were checked by the Maintenance Director to ensure it latched into the door frame properly. No concerns were found 3. The Maintenance Director provided education to the maintenance department on the importance of ensuring to room doors will close and latch to properly confine fire and smoke products to properly defend occupants in place. 4. Maintenance Director or designee will complete a monthly audit of 20 of the residents□ doors to ensure they are closing and latching properly. Maintenance will report on the results of the audit and corrective action taken at the monthly QAA committee meeting for 2 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING 01 B. WING	C 04/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

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K 712	Continued From page 3	K 712		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to conduct quarterly on each shift, varying conditions and simulation of emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. The deficient practice was evidenced by the following: Based on document review and interview on 4/19/22 with the Maintenance Director the facility fire drill reports revealed method for the simulation of emergency fire conditions were not varied: Date Type of alarm transmission - 4/1/22 Pull - 3/9/22 Page - 2/21/22 Pull - 1/11/22 Pull - 12/15/21 Page - 11/10/21 Pull	K 712	1. No residents were affected by this deficient practice 2. All the residents that reside in the facility has the potential to be affected by this deficient practice 3. Administrator re- educated the Maintenance Director and the contractor that conducts monthly fire drills on the importance of ensuring all shifts Fire drills, included the transmission of a fire alarm signal and simulation of emergency fire conditions. Also, to ensure, that Fire drills are held at expected and unexpected times at least quarterly on each shift, which includes the hours between 9:00 PM and 6:00 AM and that the staff is familiar with procedures and aware that	5/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315283	A. BUILDING **01** B. WING ______	C **04/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	**2385 SPRINGFIELD AVENUE** **VAUXHALL, NJ 07088**

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K 712	Continued From page 4 - 10/4//21 Pull - 9/19/21 Page - 8/4/21 Page - 7/20/21 Pull - 6/10/21 Page - 5/6/21 Pull - 4/9/21 Pull The findings were verified by the Maintenance Director and Administrator at the times of the observation. The Administrator was informed of the finding, at the Life Safety Code exit conference. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.7.1.4 through 19.7.1.7	K 712	drills are part of established routine. A fire drill with smoke will be conducted in the month of May. 4. The Maintenance director or designee will review the documentation of the monthly fire drills conducted to ensure they were attended by all three shifts, with varying conditions and simulation of emergency fire conditions. The Maintenance director will report the results of the audit and corrective action taken at the monthly QAA committee meeting for 2 consecutive quarters.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315283 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/31/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH MOUNTAIN HC	2385 SPRINGFIELD AVENUE VAUXHALL, NJ 07088

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 05/03/2022	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 05/03/2022	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
4/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO