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

PRINTED: 03/15/2023 FORM APPROVED OMB NO. 0938-0391

MARKE OF PROVIDER OR SUPPLIER  SOUTH MOUNTAIN HC  STREET ADDRESS, CITY, STATE, ZIP CODE 2395 SPRINGFIELD AFERING  VALVALLAL, NJ 07088  STATE OF THE CONTROL	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
SOUTH MOUNTAIN HC  SOUTH MOUNTAIN HC  (X4) ID  (X4) ID  (EACH DETRICION ON LIST BE PRECEDED BY FILL  RESULATORY OR LIST DEPTRICTIONS  (ROMPLAINT#: NJ142247  CENSUS: 141  SAMPLE SIZE: 3  THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 433, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT  VISIT.  STREET ADDRESS, CITY, STATE, JP CODE  VAUXHALL, NJ 07088  PROMITE SIZE COMPLETENCED IN THE APPROPRIATE  THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES, BASED ON THIS COMPLAINT  VISIT.			315283					
CALL   NJ 07088   CALL   NJ	NAME OF PROVIDER OR SUPPLIER				STREET ADD	RESS, CITY, STATE, ZIP CODE	,	
PROVIDERS TALS OF CORRECTION   SUMMARY STATEMENT OF DESCRIPCIES   PROVIDERS TALS OF CORRECTION AND COMPANIES   PROVIDERS TALS OF CORRECTION AND PROVIDERS OF CROSS-REPERENCED TO THE APPROPRIATE COMPANIES  F 000 INITIAL COMMENTS   F 000    COMPLAINT#: NJ142247  CENSUS: 141  SAMPLE SIZE: 3  THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES. BASED ON THIS COMPLAINT VISIT.	SOUTH M	OUNTAIN HC						
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FOOD INITIAL COMMENTS  COMPLAINT#: NJ142247  CENSUS: 141  SAMPLE SIZE: 3  THE FACILITY IS IN COMPLAINT HE PROPULATE PACIFICATION OF THE PROPULATION DE COMPLAINT WISIT.					VAUXHALL			
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CENSUS: 141  SAMPLE SIZE: 3  THE FACILITY IS IN COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES. BASED ON THIS COMPLAINT VISIT.	F 000	COMPLAINT#: NJ142247 CENSUS: 141		F	000			
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ARODATORY DIRECTOR'S OR PROVIDER/SURDI IED REDRESENTATIVE'S SIGNATURE		REQUIREMENTS OF SUBPART B, FOR LO FACILITIES. BASED	F 42 CFR PART 483, ONG TERM CARE					
ARODATORY DIRECTOR'S OR PROVIDERISLIDILIER REPRESENTATIVE'S SIGNATURE  TITLE  (VE) DATE								
ARODATORY DIRECTOR'S OR PROVIDED/SLIPBLIER REPRESENTATIVE'S SIGNATURE  TITLE  (Ve) DATE								
ABODATORY DIRECTOR'S OR PROVIDED/SLIPRI IED PEDDESENTATIVE'S SIGNATURE								
AROPATORY DIRECTOR'S OR DROVIDER/SLIDDLIER REDRESENTATIVE'S SIGNATURE  TITLE  (Ve) DATE								
	LABORATORY	DIDECTORIS OF PROVIDED	CLIDDLIED DEDDECENTATIVEIX CLOSSAT	IDE		TITLE		(Y6) DATE

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

**Electronically Signed** 

program participation.

01/14/2021