STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315259	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 US HIGHWAY 22 , MOUNTAINSIDE, New Jersey, 07092

(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) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint # 2587610 Census: 133 Sample Size:3 A Complaint Survey was conducted on 8/19/25 to 8/21/25, to determine compliance with 42 CFR Part 483 for Long Term Care facilities. During the complaint survey, a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.12(a)(1) F 600 as the facility failed to implement their [NJ Exec Order] prevention policy to protect a NJ Exec Order 26.4b1 resident (Resident #1) from NJ Exec Order 26.4b1, when Resident #1's Representative (RR #1) reported to the facility's US FOIA (b)(6) on [NJ Exec Order], that they were on the phone with the resident while the Certified Nursing Aide (CNA #1) was providing care and the resident was [NJ Exec Order 26.4b1] RR #1 stated that they spoke to CNA #1 through the phone who was not NJ Exec Order 26.4b1. On [NJ Exec Order], RR #1 [NJ Exec Order 26.4] the concern [NJ Exec Order] that CNA #1 bent the resident's NJ Exec Order 26.4b1 and [NJ Exec Order 26.4b1] on the resident. The [US FOI] immediately reported the [NJ Exec Order 26.4] to the Registered Nurse Unit Manager (RNUM #1), who went to Resident #1's room to complete a [NJ Exec Order] assessment. CNA #1 continued to work, and was not [NJ Exec Order 26.4b1] until [NJ Exec Order], three days after the [NJ Exec Order 26.4] of [NJ Exec Order 26] was made, and they worked six shifts on multiple resident care assignments. An interview with the US FOIA (b)(6)) on [NJ Exec Order], revealed that the facility initiated an investigation into the [NJ Exec Order 26.4] on [NJ Exec Order] but confirmed that CNA #1 was not [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1]. The Administration was notified of the F 600 IJ and was provided with the IJ template on 8/19/25 at 6:00 PM. An acceptable Removal Plan (RP) was received on 8/20/25	F0000		09/02/2025

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 reverse for further 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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F0000	Continued from page 1 at 2:00 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: on [NJ Exec Order], CNA #1 remained [NJ Exec Order 26.4b1] all residents who received care by CNA #1 were assessed for [NJ Exec O] [NJ Exec O] and NJ Exec Order 26.4b1 ; past three months of grievances were reviewed with no concerns for [NJ Exec Orde] Regional staff in-serviced the [US FOIA (b)] on the facility's [NJ Exec Ord] and [NJ Exec Ord] reporting policies; the [US FOIA] or designee began in-servicing all staff on [NJ Exec Ord] and [NJ Exec Ord] reporting; and the [US FOIA] or designee will quiz all staff on [NJ Exec Orde] The survey team verified the implementation of the RP on-site during the continuation of the survey, and determined the IJ for F 600 was removed as of 8/21/25.	F0000		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Complaint # 2587610 Based on interviews and review of pertinent facility documents on [NJ Ex Order 26.4(b)] it was determined that the facility failed to implement their [NJ Ex Order] prevention policy to protect NJ Ex Order 26.4(b)(1) resident (Resident #1) from [NJ Ex Order 26.4(b)(1)] when Resident #1's Representative (RR #1) reported to the facility's U.S. FOIA (b) (6)) an NJ Ex Order 26.4(b)(1). This deficient practice was identified for 1 of 3 residents	F0600	Corrective Action: -The facility implemented a corrective action plan to remediate the deficient practice including: CNA #1 remained [NJ Exec Order 26.4b1] all residents who received care by CNA #1 were assessed for NJ Ex Order 26.4(b)(1) with no concerns; past three months of grievances were reviewed with no concerns for [NJ Ex Order] Regional staff in-serviced the [U.S. FOIA (] and [U.S. FOIA] on the facility's [NJ Exec Ord] and [NJ Exec Ord] reporting policies; the DON or designee in-serviced all staff on [NJ Exec Ord] and [NJ Exec Ord] reporting; and the DON or designee issued a quiz to all staff on [NJ Exec Orde] 2. Potential to affect: -All residents identified to have received care by CNA #1 during that time were assessed with no issues identified. 3. Systemic Change: -All staff in-serviced regarding the facility abuse policy -Regional in-service completed to U.S. FOIA (b) (6) and [U.S. FOIA] on abuse policy. -Facility grievances from previous day to be reviewed at daily morning meeting. -Administrator or DON will audit all incidents in risk	09/18/2025

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F0600 SS = SQC-J	Continued from page 2 reviewed (Resident #1). On 8/4/25, RR #1 reported to the U.S. FO that they were on the phone with Resident #1 while the Certified Nursing Aide (CNA #1) was providing care, and the resident was NJ Ex Order 26.4(b)(1) RR #1 stated that they spoke to CNA #1 through the phone who was not receptive or NJ Ex Order 26.4(. On NJ Ex Order, RR #1 NJ Exec Order 26.4 the concern NJ Ex Order 26 that CNA #1 NJ Ex Or the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) the resident. The U.S. FO immediately reported the NJ Ex Order 26.4(b to the Registered Nurse Unit Manager (RNUM #1) who went to Resident #1's room to complete a NJ Exec O assessment. CNA #1 continued to work and was not NJ Exec Order 26.4b1 until NJ Ex Order, three days after the NJ Ex Order 26.4(b)(1) was made, and they worked six shifts on multiple resident care assignments. An interview with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) on NJ Ex Order 26, revealed that the facility initiated an investigation into the NJ Ex Order 26.4(b)(1), but confirmed that CNA #1 was not NJ Exec Order 26.4b1 until NJ Ex Order 2 The facility's failure to implement their NJ Exec Ord policy including protecting all residents from NJ Ex Order during an investigation, placed all residents at NJ Ex Order 26.4(b)(1). This posed the likelihood of serious physical and emotional harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order, after RR #1 NJ Exec Order CNA #1 NJ Ex Order 26.4(b)(1) Resident #1. The facility's Administration was notified of the IJ on NJ Ex Order 26 at 6:00 PM. The facility submitted an acceptable Removal Plan on NJ Ex Order 26 at 2:00 PM. The surveyor verified the implementation of the Removal Plan during an on-site visit survey on NJ Ex Order 26. The deficient practice was evidenced as follows: A review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy initialed by the LNHA with a handwritten date of 8/7/2025, included Policy Statement: All reports of abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation are […] thoroughly investigated by facility management…Reporting Allegations to the Administrator and Authorities…6. Upon receiving any allegation of abuse, neglect, exploitation, misappropriation of resident property or injury of	F0600	Continued from page 2 management daily x 4 weeks then monthly for 2 months to ensure timely reporting. -Abuse quiz completed for all active staff with 100% compliance. -Random audits of 5 residents conducted 3x's per week for 4 weeks then monthly for 3 months. Audits include psychosocial, pain and skin assessments. 4.Monitor -Results of audits will be given to the Administrator weekly and presented at the quarterly QAPI meetings.	

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F0600 SS = SQC-J	Continued from page 3 unknown source, the administrator is responsible for determining what actions (if any) are needed for protection of residents…Investigating Allegations...6. Any employee who has been accused of resident abuse is placed on leave with no resident contact until the investigation is complete… A review of the Facility Reportable Event (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on [redacted], included the date and time of event [redacted] at 10:00 AM. The FRE further included under Narrative that on [redacted], [RR #1] reported concern to facility's [redacted] that [RR #1] was on the phone with [the] resident while care being rendered by [CNA #1]. [RR #1] stated resident was [redacted] through the phone. [RR #1] stated [they] spoke to [CNA #1] through the telephone and [CNA #1] was not NJ Ex Order 26.4(b)(1) U.S. FOIA (b) (6) made aware and responded immediately to resident room for [redacted] assessment and interview. On [redacted], [RR #1's] concern [redacted] to [redacted] requesting investigation of [RR #1's] concern and on [redacted], [an Interdisciplinary Care Plan (IDCP)] team held over the phone with [RR #1] and updated [RR #1] with [redacted] result. Another [redacted] email followed. Doctor informed, [redacted] notified, and [CNA #1] [redacted] pending investigation. A review of the facility's "Investigation Report" (IR) with date of incident [redacted] and date of investigation [redacted], included the following: Summary of [redacted] Incident: On 8/4/25, [RR #1] reported a concern to [redacted] [that they were] on the phone with resident while care being rendered. [RR #1] stated that the resident was [redacted] through the phone, [RR #1] states [they] spoke to [CNA #1] on the phone and [CNA #1] was not receptive nor NJ Ex Order 26.4(b)(1). Concern was concluded with [RR #1's] satisfaction. On 8/5/25, [RR #1] [redacted] the initial concern and [redacted] [CNA #1] NJ Ex Order 26.4(b)(1) and [redacted] [the] resident. [redacted] made nursing U.S. FOIA (b) (6) aware and responded immediately to resident room for [redacted] assessment and interview following report. [redacted] resident declined [redacted] Resident did not recollect	F0600		

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F0600 SS = SQC-J	Continued from page 4 account of an incident in room or bed on this date but stated in [NJ Ex Order 26.4(b)(1)] over the weekend they [NJ Ex Order 26.4(b)(1)] [the resident], [NJ Ex Or] [the resident's] [NJ Ex Order 26.4(b)(1)] the resident's] [NJ Ex O] and [NJ Ex Order 2] [the resident]. Interview with [CNA #1] stated she was [NJ Ex Order 26.4(b)(1)] and was assisting [the resident] to [NJ Ex Order 26.4(b)(1)] by [NJ Ex Order 26.4] for [the resident's] [NJ Ex Order] which were on the [NJ Ex Order 26] no [NJ Ex Order 26.4(b)(1)] to resident. While assisting resident to [NJ Ex Order 26.4(b)(1)], resident began to [NJ Ex Order 2] and [CNA #1] stopped. [CNA #1] was able to complete care and [NJ Ex Order 26.4(b)(1)] resident into [wheelchair]. Call placed [to RR #1] for discussion of [NJ Ex Order 2] incident by [U.S. FOIA (b) (6)] with [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)] to take [CNA #1] from resident assignment due to [RR #1's] [NJ Exec Order 26.4b1] of [CNA #1's] response when on the phone. On [NJ Ex Order 26] at approximately 2:45 PM, [RR #1] sent an email regarding care concern requesting updates. On [NJ Ex Order 2] at 11:35 AM, [RR #1] sent another email awaiting another response. [RR #1] began to [NJ Exec Order 26] [CNA #1] [NJ Ex Order 26.4(b)(1)] On [NJ Ex Order 2] at 2:22 PM, another email escalating care concern was received with [NJ Ex Order 26.4(b)] of [CNA #1]. [NJ Ex Order 26.4(b)] was reported. [NJ Ex Order] were called. [CNA #1] was [NJ Exec Order 26.4b1] until investigation was completed. A review of CNA #1's statement dated [NJ Ex Order 2] at 1:30 PM, for the incident dated [NJ Ex Order 26] included that "I went to provide care for [Resident #1], who was [NJ Exec Order 26] but [RR #1] was on the phone and encouraged to finish care. While providing care I asked [Resident #1] to [NJ Ex Orde] and [the resident] [NJ Exec Order 2] I reached out my hands to assist to [NJ Ex Order 26.] since resident was [NJ Ex Order 26.4(b)(1)]. While assisting to the [NJ Ex Ord] the resident [NJ Ex Order 26.4(b)(1)] and I stopped. [RR #1] began to [NJ Ex Order 26.4(b)(1)] asking what I was doing to the patient. I responded that I was [NJ Ex Order 26.4] resident and did not do anything to [the resident]. I [NJ Ex Order 26.4(b)(1)] resident and [NJ Ex Order 26.4(b)(1)] [wheelchair] and resident thanked me. I would not [NJ Ex Orde] to any resident." The surveyor reviewed the medical record for Resident #1.	F0600		

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F0600 SS = SQC-J	Continued from page 5 A review of the Admission Record face sheet (an admission summary), revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) [redacted] A review of the Minimum Data Set (MDS), an assessment tool dated [redacted] indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated NJ Ex Order 26.4(b)(1) . The MDS further revealed that the resident required [redacted] from staff in the completion of their activities of daily living (ADLs). A review of the resident's individual comprehensive care plan (ICCP) included a focus area initiated [redacted], that the resident was NJ Ex Order 26.4(b)(1) with treatment/care [redacted] ADL, [redacted] [laboratory work], and medications related to [redacted] that treatment was NJ Ex Order 26.4(b)(1). Interventions included to [redacted] in ADL routine to accommodate [redacted] preferences, and customary routine; and if [redacted] care, leave (if safe to do so) and return later. According to CNA #1's statement, the resident was [redacted] care, and CNA #1 continued, which was not what the intervention instructed to do. On 8/19/25 at 11:38 AM, the surveyor interviewed RNUM #1, who stated that on [redacted] morning, RR #1 called the [redacted] and said, "I know that I said that, but I slept on it and felt like something happened." The [redacted] then told RNUM #1 and the [redacted] about RR #1's phone call and their conversation with RR #1 from the previous day. RNUM #1 stated then she went upstairs with the [redacted] and interviewed Resident #1, who stated, "yes [redacted] in the NJ Ex Order 26.4(b)(1)." RNUM #1 stated they then did an immediate [redacted] assessment of the resident, assessed them for [redacted] removed CNA #1 from the resident's care assignment, and she did the incident report with the [redacted] RNUM #1 further stated that with the [redacted] they called and spoke to RR #1 and informed them that they did a [redacted] and [redacted] assessment right away when they found out and started an investigation. RNUM #1 stated that RR #1 was satisfied that CNA #1 was taken off the resident's care. RNUM #1 stated on that same day, they took statements from	F0600		

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F0600 SS = SQC-J	Continued from page 6 other residents and Resident #1's roommate. RNUM #1 said that the roommate stated they did not [redacted] anything, and the [redacted] came later in the week after the [redacted] and [redacted] received an email from RR #1 regarding the investigation. On 8/19/25 at 12:21 PM, the surveyor requested CNA #1's timecard and resident care assignments for the month of [redacted] A review of the timecard provided by the facility revealed that CNA #1 worked on the following days: [redacted] CNA #1 punched in at 6:48 AM and out at 3:14 PM. [redacted] - CNA #1 punched in at 6:48 AM and out at 11:05 PM. [redacted] - CNA #1 punched in at 6:48 AM and out at 3:19 PM. [redacted] - CNA #1 punched in at 6:48 AM and out at 3:13 PM, and [redacted] - CNA #1 punched in at 6:48 AM and out at 5:37 PM. A review of the documents provided by the facility for CNA #1's resident care assignments according to Unit assignments were as follows: [redacted] - Unit 2, 7:00 AM to 3:00 PM (7-3) shift, CNA #1 was assigned to [redacted] room assignments. Resident #1 was in CNA #1's assignment. [redacted] - Unit 2, 7-3 shift, CNA #1 was assigned to [redacted] room assignments. [redacted] - Unit 2, 3:00 PM to 11:00 PM (3-11) shift, CNA #1 was assigned to [redacted] room assignments. [redacted] - Unit 1, 7-3 shift, CNA #1 was assigned to [redacted] assignments. [redacted] - Unit 1, 7-3 shift, CNA #1 was assigned to [redacted] assignments, and [redacted] - Unit 2, 7-3 and 3-11 shifts, CNA #1 was	F0600		

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F0600 SS = SQC-J	Continued from page 7 assigned to NJ Exec Order 26.4b1 room assignments. On 8/19/25 at 12:59 PM, the surveyor interviewed the U.S. FO who stated that on NJ Ex Order, RR #1 called them around 10:00 AM during morning meeting. RR #1 asked the U.S. FO if they could run upstairs and check on "[the resident]" because they "NJ Ex Order 26.4(b)(1)" when RR #1 was talking to the resident on the phone. The U.S. FO stated they went upstairs and saw the resident in their room in their wheelchair and eating their lunch. The U.S. FO stated that they asked the resident how they were, and the resident stated they NJ Exec Order 26.4b1 the U.S. FOIA name and said they NJ Ex Order 26.4(b) The U.S. FO further stated the resident was NJ Exec Order 26 and appeared to be in NJ Ex , so the U.S. FO called RR #1 while they were in the resident's room and gave them updates on the resident. The U.S. FO said the RR #1 frequently called them and asked to "check on [the resident]." The U.S. FO stated at that time, RR #1 reported they had a concern with CNA #1 "NJ Ex Order 26.4(b)(1) on the resident. The U.S. FO stated they told RR #1 that the resident was sitting in their wheelchair and eating lunch and there was NJ Ex Order 26.4 anywhere else in the room. The U.S. FO stated they then asked RR #1 if they were referring to when CNA #1 was NJ Ex Order 26.4 or NJ Ex Order 26 the resident? The US FO reported that at the end of the conversation, RR #1 was "ok" after the U.S. FO explained the NJ Exec Order 26.4 could have been during care. The U.S. FO stated they did not report that conversation with RR #1 to any of the nursing staff until NJ Ex Order, when RR #1 called again and said "after sleeping on it, I felt like it was more than the NJ Ex Order 26.4(b)(1) and [RR #1] further said that [CNA #1] was NJ Ex Order 26 the resident's NJ Ex Order 26.4(b)(1) [the resident's] NJ Ex O and NJ E [the resident] with NJ Ex Order 2." The U.S. FO stated they then reported RR #1's concerns to RNUM #1 and the U.S. FOIA who went upstairs and spoke to the resident and CNA #1. On 8/19/25 at 1:21 PM, the surveyor interviewed the U.S. FOIA and the U.S. FOIA The U.S. FOIA and the U.S. FOIA stated that when they knew of RR #1's concerns on NJ Ex Order, they started the investigation; RNUM #1 did NJ Ex Order 2 assessment on the resident, they interviewed and gathered NJ Ex Order 26 statements, and conducted a customer service in-service. They further stated they removed CNA #1 from the resident's care and assigned NJ Ex Order 26.4(b)(1) for [the resident's] care. They stated that they started the investigation, but did not NJ Exec Order 26 CNA #1 from other residents' care assignments because at the end of the day on NJ Ex Order 2 when they spoke to RR #1, RR #1 was agreeable with the result of their report. The U.S. FOIA and U.S. FOIA stated they NJ Exec Order 26.4b1 CNA #1 and	F0600		

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F0600 SS = SQC-J	Continued from page 8 called [NJ Ex Order] on [NJ Ex Order], when RR #1 emailed and [NJ Exec Order 26.4] their concerns. An acceptable Removal Plan (RP) was received on [NJ Ex Order 26] at 2:00 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: on [NJ Ex Order 26], CNA #1 remained [NJ Exec Order 26.4(b)] all residents who received care by CNA #1 were assessed for [NJ Ex Order 26.4(b)], and [NJ Ex Order 26.4(b)(1)] with no concerns; past three months of grievances were reviewed with no concerns for [NJ Ex Order] Regional staff in-serviced the [U.S. FOIA] and [U.S. FOIA] on the facility's [NJ Exec Ord] and [NJ Exec Ord] reporting policies; the [NJ Ex Ord] or designee began in-servicing all staff on [NJ Exec Ord] and [NJ Exec Ord] reporting; and the [NJ Ex Ord] or designee will quiz all staff on [NJ Ex Order]. The survey team verified the implementation of the RP on-site on [NJ Ex Order 26.]. N.J.A.C. 8:39-4.1(a)5	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance	F0609	Corrective Action: -The report was submitted to the Department of Health upon initiation of the investigation. 2. Potential to Affect: -The Director of Nursing (DON) and Administrator reviewed the past 90 days of grievance logs to ensure all other allegations were reported timely. -No additional late reports were identified. 3. Systemic Change: -The DON re-educated all staff immediately on the facility's Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating Policy, with emphasis on the requirement to report allegations immediately to the Administrator or DON. -The DON or designee will review all incident reports at the end of each shift to ensure timely reporting requirements are met. -The Administrator or designee will review all facility	09/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315259	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 US HIGHWAY 22 , MOUNTAINSIDE, New Jersey, 07092

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F0609 SS = D	Continued from page 9 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Complaint # 2587610 Based on interviews and review of pertinent facility documents on NJ Ex Order 26.4(b), it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) an NJ Ex Order 26.4(b)(1) [redacted] that occurred on NJ Ex Order. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1), and was evidenced by the following: A review of the Facility Reportable Event (FRE) submitted by the facility to the New Jersey Department of Health (NJDOH) on NJ Ex Order 26, included the date and time of event NJ Ex Order 2 at 10:00 AM. The FRE further included under Narrative that on NJ Ex Order, [RR #1] reported concern to facility's U.S. Fo that [RR #1] was on the phone with [the] resident while care being rendered by [CNA #1]. [RR #1] stated resident was NJ Ex Order through the phone. [RR #1] stated [they] spoke to [CNA #1] through the telephone and [CNA #1] was not NJ Ex Order 26.4(b)(1). U.S. FOIA (b) (6) made aware and responded immediately to resident room for NJ Ex Ord assessment and interview. On NJ Ex Order, [RR #1's] concern NJ Exec Order 26.4 to NJ Ex Order 26.4(b)(1) requesting investigation of [RR #1's] concern and on NJ Ex Order, [an Interdisciplinary Care Plan (IDCP)] team held over the phone with [RR #1] and updated [RR #1] with NJ Ex Ord result. Another NJ Exec Order 26.4 email followed. Doctor informed, NJ Ex Orde notified, and [CNA #1] NJ Exec Order 26.4b1 pending investigation. The FRE further indicated that the event was called in on NJ Ex Order at 6:30 PM. A review of the facility's "Investigation Report" (IR) with date of inciden NJ Ex Order 26 and date of investigation NJ Ex Order, included the following: Summary of NJ Exec Order Incident: On 8/4/25, [RR #1] reported a concern to U.S. Fo [that they were] on the phone with resident while care being rendered. [RR #1] stated that the resident was NJ Ex Order through the phone, [RR #1] states [they] spoke to [CNA #1] on the phone and [CNA #1] was not receptive nor NJ Ex Order 26.4(b)(1). Concern was concluded with [RR #1's] satisfaction.	F0609	Continued from page 9 documentation for the past 24 hours each weekday during morning meeting (72 hours on Mondays) to ensure timely reporting is met. 4. Monitoring: -The Administrator or designee will audit all incident reports weekly x 8 weeks, then monthly x 3 months to ensure reporting to the DOH occurred within the required timeframes. -Results will be presented to the quarterly QAPI committee meeting x 2	

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F0609 SS = D	Continued from page 10 On [NJ Ex Order 2] [RR #1] [NJ Exec Order 26.4] the initial concern and [NJ Ex Order 2] [CNA #1] NJ Ex Order 26.4(b)(1) and [NJ Ex Order 2] [the] resident. [U.S. FO] made U.S. FOIA (b) (6) aware and responded immediately to resident room for [NJ Ex Or] assessment and interview following report. [NJ Ex] resident declined [NJ Ex Or] Resident did [NJ Exec Order 26.4b1] account of an incident in room or bed on this date but stated in [NJ Ex Order 26.4(b] over the weekend they [NJ Ex Order 26.4(b)(1)] the resident], [NJ Ex O] [the resident's] [NJ Ex Order 26.4(b)(1)], [NJ Ex Orde] [the resident's] [NJ Ex O] and NJ Ex Order 26.4(b)(1) [the resident]. Interview with [CNA #1] stated she was [NJ Ex Order 26.4] resident [NJ Ex Or] and was assisting [the resident] to [NJ Exec] to the [NJ Exec Order 26.4b] by reaching for [the resident's] [NJ Exec Or] which were on the edge of bed, no intention to [NJ Ex Order 26.4(b)(1)] resident. While assisting resident to the other side, resident NJ Ex Order 26.4(b)(1) and [CNA #1] stopped. [CNA #1] was able to complete care and transferred resident into [wheelchair]. Call placed [to RR #1] for discussion of [NJ Ex Order 2] incident by U.S. FOIA (b) (6) with [NJ Exec Order 26.4b1] and agreeable to take [CNA #1] from resident assignment due to [RR #1's] NJ Ex Order 26.4(b)(1) of [CNA #1's] response when on the phone. On [NJ Ex Order 2] at approximately 2:45 PM, [RR #1] sent an email regarding care concern requesting updates. On [NJ Ex Order] at 11:35 AM, [RR #1] sent another email awaiting another response. [RR #1] began to [NJ Exec Order 2] [CNA #1] [NJ Ex Order 26.4(b)(1)] On [NJ Ex Order 2] at 2:22 PM, another email [NJ Exec Order 26.4] care concern was received with [NJ Ex Order 26.4(b] of [CNA #1]. [NJ Ex Order 26.4(b)] was reported. [NJ Ex Order] were called. [CNA #1] was [NJ Exec Order 26.4b1] until investigation was completed. A review of CNA #1's statement dated [NJ Ex Order 2] at 1:30 PM, for the incident dated [NJ Ex Order 26] included that "I went to provide care for [Resident #1], who was [NJ Ex Order 26.4] but [RR #1] was on the phone and encouraged to finish care. While providing care I asked [Resident #1] to [NJ Ex Orde] and [the resident] [NJ Ex Order 26.] I reached out my hands to assist to [NJ Ex Order 26.] since resident was NJ Ex Order 26.4(b)(1). While assisting to [NJ Ex Order 26.4] the resident began to [NJ Ex Order 2] and I stopped. [RR #1] began to NJ Exec Order 26.4b1 . I responded that I was cleaning resident and NJ Ex Order 26.4(b)(1) to [the resident]. I finished [NJ Ex Order 26.4] resident and [NJ Ex Order 26.4(b)(1] to [wheelchair] and resident thanked me. I would not [NJ Ex Order] any resident." The surveyor reviewed the medical record for Resident	F0609		

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F0609 SS = D	Continued from page 11 #1. A review of the Admission Record face sheet (an admission summary), revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) and NJ Ex Order A review of the Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 2 indicated the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1) . The MDS further revealed that the resident required assistance from staff in the completion of their activities of daily living (ADLs). On 8/19/25 at 12:59 PM, the surveyor interviewed the U.S. FO who stated that on NJ Ex Order 26 RR #1 called them around 10:00 AM during morning meeting. RR #1 asked the U.S. FO if they could run upstairs and check on "[the resident]" because they 'NJ Ex Order 26.4(b)(1)' when RR #1 was talking to the resident on the phone. The U.S. FO stated they went upstairs and saw the resident in their room in their wheelchair and eating their lunch. The U.S. FO stated that they asked the resident how they were, and the resident stated they NJ Exec Order 26.4b1 the U.S. FOIA name and said they were 'NJ Ex O The U.S. FO further stated the resident was NJ Exec Order 26 and appeared to be NJ Ex Ord , so the U.S. FO called RR #1 while they were in the resident's room and gave them updates on the resident. The U.S. FO said the RR #1 frequently called them and asked to "check on [the resident]." The U.S. FO stated at that time, RR #1 reported they had a concern with CNA #1 'NJ Ex Order 26.4(b)(1) the resident. The U.S. FO stated they told RR #1 that the resident was sitting in their wheelchair and eating lunch and there was NJ Ex Order 26.4 anywhere else in the room. The U.S. FO stated they then asked RR #1 if they were referring to when CNA #1 was NJ Ex Order 26.4 or NJ Ex Order 26 the resident? The U.S. FO reported that at the end of the conversation, RR #1 was 'NJ Ex after the U.S. FO explained the NJ Ex Order 26.4(b) could have been during care. The U.S. FO stated they did not report that conversation with RR #1 to any of the nursing staff until NJ Ex Order , when RR #1 called again and said "after sleeping on it, I felt like it was more than the NJ Ex Order 26.4(b)(1) and [RR #1] further said that [CNA #1] was NJ Ex Order 26.4(b)(1) [the resident's] NJ Ex O and NJ E [the resident] NJ Ex Order 26.4(b)(1) The U.S. FO stated they then reported RR #1's concerns to RNUM #1 and the U.S. FOIA who went upstairs and spoke to the	F0609		

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F0609 SS = D	Continued from page 12 resident and CNA #1. On 8/19/25 at 1:21 PM, the surveyor interviewed the U.S. FOIA and the U.S. FOIA. The U.S. FOIA and the U.S. FOIA stated that when they knew of RR #1's concerns on NJ Ex Order, they started the investigation; RNUM #1 did a NJ Ex Or assessment on the resident, they interviewed and gathered witness statements and conducted a customer service in-service. They further stated they removed CNA #1 from the resident's care and assigned NJ Ex Order 26.4(b)(1) for [the resident's] care. They stated that they started the investigation, but did not suspend CNA #1 from other residents' care assignments because at the end of the day on NJ Ex Order 2 when they spoke to RR #1, RR #1 was NJ Exec Order 26.4 with the result of their report. The U.S. FOIA and U.S. FOIA stated they NJ Exec Order 26.4b1 CNA #1 and called NJ Ex Orde or NJ Ex Order 2, when RR #1 emailed and escalated their concerns. They further stated they called in the event to NJDOH on that day NJ Ex Order but submitted the FRE [AAS-45] to NJDOH on NJ Ex Order 26. The U.S. FOIA and U.S. FOIA stated that they were aware that incidents involving NJ Ex Order and NJ Ex Order 2 have to be reported immediately to NJDOH. On 8/19/25 at 3:49 PM, the surveyor interviewed the U.S. FOIA regarding the facility's policy and procedure on NJ Ex Order 26.4(b)(1) and reporting. The U.S. FOIA stated that on NJ Ex Order, RR #1 was agreeable with the facility's explanation of events and there were no signs of NJ Ex Order and the resident was NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(1) so we did not consider it as NJ Ex Order 2 A review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy initialed by the LNHA with a handwritten date of 8/7/2025, included Policy Statement: All reports of abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation are […] thoroughly investigated by facility management…Reporting Allegations to the Administrator and Authorities:1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law... N.J.A.C 8:39-9.4(f)	F0609		

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F0000	INITIAL COMMENTS An on-site revisit for the facility's Plan of Correction was conducted on 09/19/2025 in relation to the 08/21/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 493, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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