STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315259	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 ROUTE 22 WEST MOUNTAINSIDE, NJ 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
F 000	INITIAL COMMENTS Complaint#: NJ172132, NJ175519 Census: 128 Sample: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		8/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/19/2024

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 DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 690	Continued From page 1 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint #: NJ172131, NJ175519 Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to obtain a physician's order for the care of an NJ Exec Order 26.4b1 for Resident #2. This deficient practice was identified for 1 of 4 residents (Resident #2) reviewed for the use of an NJ Exec Order 26.4b1 and was evidenced by the following: According to the Admission Record, Resident #2 had diagnoses that included, but were not limited to, NJ Exec Order 26.4b1 Review of Resident #2's Quarterly Minimum Data Set (MDS), dated NJ Exec Order 26.4b1, included the	F 690	Corrective Action NJ Exec Order 26.4b1 was NJ Exec Order 26.4 immediately for resident #2 and received an order from the physician to NJ Exec Order 26.4b1 and as needed. Potential to Affect All residents with indwelling catheters and suprapubic catheters have the potential to be affected. Systemic Change The Director of Nursing/Designee will educate licensed nurses, Unit Managers and Nursing Supervisors on ensuring physician orders are in place upon admission, readmission or with change of condition requiring an indwelling Foley or suprapubic catheters, in accordance with facility policy/or as per physician recommendation. An audit was completed to ensure that all residents with indwelling and suprapubic catheters have a physician order with proper diagnosis and in accordance with facility policy.	

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	315259	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092

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F 690	Continued From page 2 resident had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated that the resident was [redacted]. Further review of the MDS revealed the resident had an [redacted] and had [redacted] to [redacted] and [redacted]. Review of Resident #2's Care Plan (CP) revealed a "Focus" initiated on [redacted], for the resident's use of an [redacted] due to [redacted] with [redacted]. The CP included an intervention, initiated on [redacted], to [redacted] per physician order, every month and as needed. Review of Resident #2's Order Summary Report (OSR), for active orders as of [redacted] showed there were no orders for [redacted] or [redacted]. Review of Resident #2's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of [redacted] through [redacted] did not reveal any documentation of [redacted] or [redacted] for Resident #2. Review of Resident #2's Progress notes for [redacted], revealed no documentation that Resident #2's [redacted] was [redacted] or [redacted] was completed. Review of Resident #2's progress note documentation dated [redacted], revealed that Resident #2's [redacted] was [redacted] on [redacted]. Prior to [redacted], Resident #2's [redacted] was	F 690	Monitoring The Unit Manager/Designee will conduct 3 sample audits of indwelling catheters or suprapubic catheters to ensure physician orders in place and report to DON monthly. The results of these audits will be reviewed at the quarterly QAPI Committee meeting for 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315259	A. BUILDING _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092

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F 690	Continued From page 3 NJ Exec Order 26.4 NJ Exec Order 26.4b1 prior on NJ Exec Order 26.4b1. During an interview with the Surveyor on 07/31/24 at 3:05 PM, the US FOIA (b)(6) stated, "there should be an order if a resident has a NJ Exec Order 26.4b1. A NJ Exec Order 26.4b1 should be NJ Exec Order 26.4 every 30 days." The US FOIA (b)(6) further stated that there should have been an order for NJ Exec Order 26.4b1. During an interview with the Surveyor on 7/31/24 at 2:44PM, the US FOIA (b)(6) stated that prior to the Concern Form dated NJ Exec Order 26.4b1 from Resident #2's representative, there was no order for NJ Exec Order 26.4b1. The US FOIA (b) also stated that there should have been an order for the NJ Exec Order 26.4b1 and that the NJ Exec Order 26.4b1 should have been NJ Exec Order 26.4b1 and as needed as per policy. The US FOIA (b) further stated, "the facility's policy was not followed." Review of the facility's "Foley Catheter Care and Change Policy," revised on 09/2014, indicated that indwelling Foley catheter be changed monthly and as needed to prevent infection, clogging, and catheter-associated urinary tract infections. NJAC 8:39 - 19.4 (a)(5)	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062021	A. BUILDING: _____ B. WING _____	C 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092

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S 000	Initial Comments Complaint#: NJ172132, NJ175519 Census: 128 Sample: 4 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
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: Complaint #: NJ172132, NJ175519 Based on interviews and review of facility documents on 07/31/2024, it was determined that the facility failed to ensure staffing ratios were met for 1 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include:	S 560	S560 Staffing Deficiency I. Reinforcement and education for staffing coordinator to meet staffing ratios. Education of staffing coordinator for review of vacation requests/Paid Time Off to ensure staffing ratios are met prior to approval. Incentives and retention efforts for prevention of callouts.	8/26/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/19/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062021	A. BUILDING: _____ B. WING _____	C 07/31/2024

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S 560	Continued From page 1 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 as 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. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to complaint survey from 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 1 of 14-day shifts, as follows: On 07/22/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs.	S 560	Certified Nursing Assistants were requested from our current staffing agency platforms. Offered overtime to to accommodate any open shifts. Efforts to hire facility staff will continue until there are adequate staffing to serve all residents. The facility will continue to utilize staffing agencies to fill open spots in the schedules across all shifts. II. All residents are at risk for this same deficiency. III. Additional staffing agencies are in place to supplement certified nursing assistant shortages. Recruitment efforts and wage adjustments were put into place and continue. Job fair for recruitment scheduled as well as Online job postings including social media platforms. collaboration with Certified Nursing Assistant schools to obtain and recruit new staff. Advertising to include shift differentials, referral and sign on bonuses. IV. Weekly meetings will be held with both Human Resources and staffing coordinator in attendance with Administrator to review schedules for adequate staffing and identify areas of need. Human Resources will audit staffing schedules weekly and report to Administrator to ensure patient and staffing ratios are met. Human Resources will report recruitment and retention data trends to QAPI meeting for the next consecutive 6 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315259	A. Building B. Wing	8/29/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092

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 F0690 Reg. # 483.25(e)(1)-(3) LSC	Correction Completed 08/28/2024	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	
7/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062021	A. Building B. Wing	8/29/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAINSIDE SKILLED NURSING AND REHAB	1180 ROUTE 22 WEST MOUNTAINSIDE, NJ 07092

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 08/26/2024	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	
7/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO