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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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 Standard Survey 12/23/20 Census: 97 Sample Size: 23 Complaint #NJ00141817 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to consistently maintain communication with the [redacted] center and coordinate medication administration according to the [redacted] schedule. This deficient practice was observed for [redacted] residents (Resident [redacted]) reviewed for [redacted] services. The deficient practice was evidenced by the following: On 12/17/20 at 12:47 PM, the surveyor observed the resident in bed awake with [redacted] The resident informed the surveyor that they go	F 698	1. Residents affected by the deficient practice One resident was affected by the deficient practice - resident [redacted] 2. Other residents who could be affected by the deficient practice. All [redacted] patients are at risk of being affected by the deficient practice. 3. How facility will correct deficient practice.	1/14/21

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

Electronically Signed | 01/14/2021

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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 698	Continued From page 1 Executive Order 26, 4.b. Executive Order 26, 4.b. . The resident Executive Order 26, 4.b. and Executive Order 26, 4.b. . The surveyor reviewed Resident Executive 's medical records which revealed the following: According to the admission record, Resident Executive was Executive Order 26, 4.b. The November 2020 and December 2020 Executive Order 26, 4.b. Orders (PO) and Executive Order 26, 4.b. Executive Order 26, 4.b. Records (MAR) revealed the following medications Executive Order 26, 4.b. , Executive Order 26, Resident Executive was Executive Ord The medications with a Executive Order 26, 4.b. M administration time were: Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. The Progress Notes dated Executive Order 26, 4.b. indicated the nurses documented when Resident Executive went out to Executive Order 26 and returned from Executive Order 26 on the following dates: Executive Order 26, 4.b. The facility had Executive Order 26, 4.b. Forms (HCF) to go with the resident as part of the coordination of care with the Executive Order 26, 4.b. . There was no HCF for Executive Order 26, 4.b.	F 698	(a)DON requested and received missing Executive Order 26 communication forms for affected resident (Executive)from the Executive Order 26 center. (b) Don adjusted medication times to accommodate Executive Order 26 schedules. 4. Measures taken to ensure deficient practice does not recur. (a) Education - DON/designee educated all nurses on completing Executive Order 26, 4.b. Executive Or (HCF), reviewing HCF forms/assessing HD access site upon return from Executive Order 2 and documenting receipt of HCF form from Executive Order 2 patients returning from Executive Order 2 . (b) Education - DON/Designee educated nursing staff to 'Create care plans specific to residents on Executive Order 26, 4.b. including adjusting medication according to Executive Order 2 schedule and HCF to be completed by facility and communication with Executive Order 2 center. (c) DON or designee to review all resident receiving Executive Order 2 for completed/communication form, documentation (d) A review of all Executive Order 2 patients in the building shows no other Executive Order 2 patient was affected. 5. Plans to monitor to make sure solutions are sustained. (a)DON/designee to audit all HD patients to ensure all patients have Executive Order 26, 4.b. form in the chart 5 x week for 4 weeks, then once a week for 4 weeks. (b) DON/designee to audit receipt of HCF	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	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 698	Continued From page 2 The comprehensive care plan titled "The resident needs Executive Order 26, 4.b. does not include interventions to include the adjust medications according to the Executive Order 26 schedule, nor was there an intervention to include HCF to be completed by the facility and Executive Order 26, 4.b. On 12/21/20 at 12:17 PM, the surveyor interviewed the Licensed Practical Nurse Supervisor #1 (LPNS #1) regarding the missing HCFs and the medications that were scheduled while the resident was out to Executive Order 2. She stated that if the resident doesn't return from Executive Order 2 with the HCF, that the nurse should call the Executive Order 26, 4.b. and request a copy. LPNS #1 confirmed that the resident Executive the Executive Order 26, 4.b. She wasn't aware the Executive Order 26, 4.b. were signed by the Executive Order 26, 4.b. as administered when Resident Executive was out to Executive Order 2. LPNS #1 further stated she would contact the Executive Order 26, 4.b. to obtain the Executive Order 26, 4.b. Forms that were missing. At 2 PM, the surveyor discussed the above concern with the Administrator and Director of Nursing (DON). In addition, LPNS #1 had not provided the missing HCFs. On 12/22/20 at 9:30 AM, the DON informed the surveyor that she had communicated with three 3-11 nurses who were on duty on the days Resident Executive was out to Executive Order 26 The response from the 3-11 nurses was that they gave the 5 PM medications when the resident returned between 6:30 PM and 7 PM. The DON informed the surveyor that LPNS #2 was currently in the	F 698	using the 24 hour report and Eagle room Executive Order 2 tool in the morning meetings, 5 x a week for 4 weeks, then weekly for 2 months. (c) DON/designee will monitor provision of medication times for all Executive Order 2 patients to ensure Executive Order 2 times do not conflict medication administrations, 5 x weekly for four weeks then weekly for 4 weeks. 6. discontinuation of or changes in corrective measures will be determined in the monthly and Quarterly committee meetings.	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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 698	Continued From page 3 building and available for an interview. On 12/22/20 at 12:12 PM, the surveyor interviewed LPNS #2 regarding the Executive Order 26, 4.b. and Executive Order 26, 4.b. scheduled on Executive Order 26, 4.b.. She stated she didn't remember if the resident returned with the Executive Order 26, 4.b., and if the resident didn't return with the form, she would call the Executive Order 26, 4.b.. When the surveyor questioned LPNS #2 about the Executive Order 26, 4.b., she stated that she gave the resident the Executive Order 26, 4.b. when the resident returned from Executive Order 26, 4.b. . The facility did not have a policy and procedure related to Executive Order 26, 4.b. for residents who are Executive Order 26, 4.b. or for the Executive Order 26, 4.b. On 12/23/20 at 11 AM, the DON did not provide any additional information regarding the missing Executive Or	F 698		
F 812 SS=F	NJAC 8:39-27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		1/14/21

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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 812	Continued From page 4 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 12/6/20 at 9:19 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. The surveyor observed a four-pound jar of grape jelly opened and more than half empty stored on a shelf next to a tub of peanut butter in the sandwich prep area. The jelly had an expiration date of 3/11/22 and an open date of 11/30/20. When interviewed at the time, the FSD said jelly should be stored in the refrigerator when not in use, however, a Food Service Worker (FSW) was, "Just using it." The surveyor felt the jar which felt room temperature. The surveyor requested the FSD take temperature of the jelly using a calibrated thermometer. The temperature on the jelly was 73 Fahrenheit. The FSD read the label which indicated the product should be	F 812	1. Residents affected by the deficient practice. No resident was affected by the deficient practice 2. other residents who could be affected by the deficient practice. All residents are at risk of being affected by the deficient practice. 3. measures taken to ensure that deficient practice does not recur. (a) Education - All dietary staff were educated by FSD as follows "All opened food/product/container should be stored according to recommendation" All food that requires refrigeration when open should be refrigerated. (b) Education - All dietary staff and other staff were educated by FSD as follows "All personnel who has beard should wear beard guard in any part of the kitchen and all staff should wear professional hair net when inside the kitchen" (c) The FSW who was observed not wearing beard guard by the surveyor received a one on one education on	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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 812	Continued From page 5 refrigerated after opening. The FSD discarded the jelly. 2. The surveyor observed a FSW with a curly beard that was poking out around his surgical mask. When the surveyor asked the length of his beard, the FSW stretched out a piece of the curly beard hair and said it was about an inch or 2 long. The FSW said he didn't need a beard guard in this part of the kitchen, only in the food prep area. At 10:30 AM, the surveyor observed the same FSW labeling snacks in a food preparation area counter. The FSW said a beard guard was not needed in the area (of the kitchen). The FSD handed the FSW a beard guard and he returned wearing the guard. The FSD said beard guards should be worn anywhere in the kitchen for any length of beard. 3. The surveyor observed a FSW pre-rinse dirty dishes to feed into the dishwasher in the dish machine area. Wearing the same pair of soiled gloves, the FSW moved to the clean dish area of the dish machine and began to unload and stack clean plates into the plate warmer. When interviewed at the time, the FSW said she should have rinsed her gloves before touching the clean dishes, reflected for a moment, and said she should wash her gloves before touching the clean dishes. The FSD said all the dishes will have to be rewashed and sanitized. The surveyor observed the FSW wash her hands. There was not a box of gloves in the dish area, The FSD placed a box on the shelf in the area and the FSW put on a pair of clean gloves. The surveyor observed the FSW	F 812	when, and where to wear beard guard and he verbalized understanding. (d)Education - All dietary were educate by FSD as follows "When one staff is washing and rinsing utensils, staff should change gloves after washing and before rinsing or touching clean utensils" (e)The FSW observed by the surveyor pre-rinsing dirty dishes without changing gloves received a one on one on the proper use of gloves when handling dishes. (f) All dietary and nursing staff were educated by Dietician as follows "All food, drinks, juice, consumable items should be dated when opened, that is, the date container was opened should be indicated on the container" (g)All open containers were inspected by the dietician. All were found to be dated. Also all opened container that need to be refrigerated were properly refrigerated. 4. Plans to monitor corrective actions to make sure solutions are sustained. (a) FSD or designee to monitor staff to ensure that any staff n the kitchen area covers hair with professional hair cover and staff with beard wear beard guard in the kitchen, daily x 4 weeks and the weekly for 4 weeks. (b)FSD or designee to monitor dish washing staff to ensure proper practice of changing gloves between touching dirty dishes and clean dishes, daily x 4 weeks then weekly for 4 weeks. (c) Dietician to audit open containers to ensure that all open containers has date of opening and that they are properly	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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 812	Continued From page 6 remove the dishes from the plate storage cart to be rewashed. 4. The surveyor observed a 10-pound bag of elbow macaroni that was open and undated in the dry storage area. When interviewed at the time, the FSD it should be dated when its opened and immediately discarded the macaroni. On 12/22/20 at 11:39 AM, the Administrator confirmed jelly should refrigerated after opening, beard guards should be worn in any part of the kitchen for any length of beard, if one person was working at the dish machine, staff should change gloves in between working with the dirty and clean dishware and any container of food that is opened should be dated with the date of opening. The surveyor reviewed the facility's unsigned procedure entitled Dishwasher Operation, provided by the Administrator, with a date of 11/2020. Changing gloves between the dirty and clean side of the dish machine was not addressed. The surveyor reviewed the facility's unsigned procedure entitled Hair Restraints, provided by the Administrator, with a date of 11/2020. The procedure indicated hair restraints, including beard guards, should be worn in the kitchen. The surveyor reviewed the facility's unsigned procedure entitled An Introduction to Safe Food Handling, provided by the Administrator, with a date of 11/2020. The procedure indicated temperature of food should be controlled to prevent foodborne illness. NJAC 8:39-17.2(g)	F 812	refrigerated, daily x 4 weeks and then weekly for 4 weeks. 5. discontinuation of, or changes in corrective measures will be determined in the monthly/quarterly QAPI committee meeting.	

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 12/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB (MOUNTAINSIDE)	**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

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
315259 (Y1)	A. Building B. Wing (Y2)	1/21/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB - MOUNTAINSIDE	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 F0698 Reg. # 483.25(l) LSC	Correction Completed 01/21/2021	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/19/2021	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	
12/23/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO