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	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountainside Skilled Nursing and Rehab	1180 US Highway 22 Mountainside, NJ 07092

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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.

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Complaint # 2587610 Based on interviews and review of pertinent facility documents on 08/19/25, it was determined that the facility failed to implement their abuse prevention policy to protect a cognitively impaired resident (Resident #1) from physical abuse when Resident #1's Representative (RR #1) reported to the facility's Social Worker (SW) an allegation of abuse. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1). On 8/4/25, RR #1 reported to the SW that they were on the phone with Resident #1 while the Certified Nursing Aide (CNA #1) was providing care, and the resident was screaming. RR #1 stated that they spoke to CNA #1 through the phone who was not receptive or admitting any wrongdoing. On 8/5/25, RR #1 escalated the concern alleging that CNA #1 bent the resident's fingers/hand back and poured liquid on the resident. The SW immediately reported the allegation to the Registered Nurse Unit Manager (RNUM #1) who went to Resident #1's room to complete a body assessment. CNA #1 continued to work and was not suspended until 8/8/25, three days after the allegation of physical abuse was made, and they worked six shifts on multiple resident care assignments. An interview with the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) on 8/19/25, revealed that the facility initiated an investigation into the allegation on 8/5/25, but confirmed that CNA #1 was not suspended until 8/8/25. The facility's failure to implement their abuse policy including protecting all residents from abuse during an investigation, placed all residents at risk for abuse. This posed the likelihood of serious physical and emotional harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 8/5/25, after RR #1 alleged CNA #1 physically abused Resident #1. The facility's Administration was notified of the IJ on 8/19/25 at 6:00 PM. The facility submitted an acceptable Removal Plan on 8/20/25 at 2:00 PM. The surveyor verified the implementation of the Removal Plan during an on-site visit survey on 8/21/25. 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 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 8/11/25, included the date and time of event: 8/4/25 at 10:00 AM. The FRE further included under Narrative that on 8/4/25, [RR #1] reported concern to facility's SW that [RR #1] was on the phone with [the] resident while care being rendered by [CNA #1]. [RR #1] stated resident was yelling through the phone. [RR #1] stated [they] spoke to [CNA #1] through the telephone and [CNA #1] was not admitting to wrongdoing. Nursing unit manager made aware and responded immediately to resident room for body assessment and interview. On 8/7/25, [RR #1's] concern escalated to accusations requesting investigation of [RR #1's] concern and on 8/8/25, [an Interdisciplinary Care Plan (IDCP)] team held over the phone with [RR #1] and updated [RR #1] with good result. Another escalated email followed. Doctor informed, police notified, and [CNA #1] suspended pending investigation. A review of the facility's Investigation Report (IR) with date of incident 8/4/25, and date of investigation 8/8/25, included the following: Summary of Alleged Incident: On 8/4/25, [RR #1] reported a concern to SW [that they were] on the phone with resident while care being rendered. [RR #1] stated that the resident was yelling through the phone, [RR #1] states [they] spoke to [CNA #1] on the phone and [CNA #1] was not receptive nor admitting to wrongdoing. Concern was concluded with [RR #1's] satisfaction. On 8/5/25, [RR #1] escalated the initial concern and alleged [CNA #1] bent fingers/hand back and poured liquid on [the] resident. SW made nursing unit manager aware and responded immediately to resident room for body assessment and interview following report. No redness, no swelling, no bruising noted, skin intact, resident declined pain. Resident did not recollect account of an incident in room or bed on this date but stated in [a house of worship] over the weekend they jumped on top of [the resident], bent [the resident's] hands back, pulled [the resident's] hair, and poured liquid on [the resident]. Interview with [CNA #1] stated she was washing resident body and was assisting [the resident] to turn to the other side by reaching for [the resident's] hands which were on the edge of bed, no intention to cause harm to resident. While assisting resident to the other side, resident began to

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # 2587610 Based on interviews and review of pertinent facility documents on 08/19/25, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) an allegation of physical abuse that occurred on 8/4/25. 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 8/11/25, included the date and time of event: 8/4/25 at 10:00 AM. The FRE further included under Narrative that on 8/4/25, [RR #1] reported concern to facility's SW that [RR #1] was on the phone with [the] resident while care being rendered by [CNA #1]. [RR #1] stated resident was yelling through the phone. [RR #1] stated [they] spoke to [CNA #1] through the telephone and [CNA #1] was not admitting to wrongdoing. Nursing unit manager made aware and responded immediately to resident room for body assessment and interview. On 8/7/25, [RR #1's] concern escalated to accusations requesting investigation of [RR #1's] concern and on 8/8/25, [an Interdisciplinary Care Plan (IDCP)] team held over the phone with [RR #1] and updated [RR #1] with good result. Another escalated email followed. Doctor informed, police notified, and [CNA #1] suspended pending investigation. The FRE further indicated that the event was called in on 8/8/25 at 6:30 PM. A review of the facility's Investigation Report (IR) with date of incident 8/4/25, and date of investigation 8/8/25, included the following:Summary of Alleged Incident:On 8/4/25, [RR #1] reported a concern to SW [that they were] on the phone with resident while care being rendered. [RR #1] stated that the resident was yelling through the phone, [RR #1] states [they] spoke to [CNA #1] on the phone and [CNA #1] was not receptive nor admitting to wrongdoing. Concern was concluded with [RR #1's] satisfaction.On 8/5/25, [RR #1] escalated the initial concern and alleged [CNA #1] bent fingers/hand back and poured liquid on [the] resident. SW made nursing unit manager aware and responded immediately to resident room for body assessment and interview following report. No redness, no swelling, no bruising noted, skin intact, resident declined pain. Resident did not recollect account of an incident in room or bed on this date but stated in a mosque over the weekend they jumped on top of [the resident], bent [the resident's] hands back, pulled [the resident's] hair, and poured liquid on [the resident]. Interview with [CNA #1] stated she was washing resident body and was assisting [the resident] to turn to the other side by reaching for [the resident's] hands which were on the edge of bed, no intention to cause harm to resident. While assisting resident to the other side, resident began to yell out and [CNA #1] stopped. [CNA #1] was able to complete care and transferred resident into [wheelchair]. Call placed [to RR #1] for discussion of alleged incident by unit manager with good result and agreeable to take [CNA #1] from resident assignment due to [RR #1's] negative perception of [CNA #1's] response when on the phone.On 8/7/25, at approximately 2:45 PM, [RR #1] sent an email regarding care concern requesting updates.On 8/8/25 at 11:35 AM, [RR #1] sent another email awaiting another response. [RR #1] began to escalate [CNA #1] allegations.On 8/8/25 at 2:22 PM, another email escalating care concern was received with allegation of [CNA #1]. Allegation was reported. Police were called. [CNA #1] was suspended until investigation was completed. A review of CNA #1's statement dated 8/5/25 at 1:30 PM, for the incident dated 8/4/25, included that I went to provide care for [Resident #1], who was refusing, but [RR #1] was on the phone and encouraged to finish care. While providing care I asked [Resident #1] to roll to other side and [the resident] refused. I reached out my hands to assist to roll over since resident was grabbing edge of bed. While assisting to the other side, the resident began to yell out and I stopped. [RR #1] began to yell through the phone asking what I was doing to the patient. I responded that I was cleaning resident and did not do anything to [the resident]. I finished dressing resident and transferred to [wheelchair] and resident thanked me. I would not cause harm to any resident. The surveyor reviewed the medical record for Resident #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: metabolic encephalopathy (a condition where the brain's function is impaired due to underlying metabolic disturbance), cerebral infarction (stroke), hypotension (low blood pressure), insomnia (sleep disorder), obesity, muscle weakness, and type 2 diabetes mellitus without complications. A review of the Minimum Data Set (MDS), an assessment tool dated 6/2/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated a severely impaired cognition. 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 SW, who stated that on 8/4/25, RR #1