

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER South Mountain Hc		STREET ADDRESS, CITY, STATE, ZIP CODE 2385 Springfield Avenue Vauxhall, NJ 07088	
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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interviews and review of pertinent facility documents, it was determined that the facility failed to ensure the development and implementation of menus to consistently provide adequate portions of milk and bread to residents in accordance with the facility's diet manual, policy and national nutritional standards for a four-week cycle menu. This deficient practice was evidenced by the following: On 8/18/25 at 8:59 AM, during entrance conference it was determined that the facility was licensed for a capacity of 195 beds and had a current census of 189 beds. On 8/18/25 at 10:13 AM, the surveyor toured the kitchen with the Food Service Director (FSD) in the presence of a second surveyor. At the end of the tour, the surveyor requested a copy of the facility's four-week cycle menus (reflects the regular diet) and the extensions (a breakdown of what all the therapeutic and mechanically altered diets received). On 8/19/25 at 12:15 PM, the surveyor observed lunch meal service in the first-floor main dining area. There was no milk on the beverage cart and creamers were offered for coffee. In addition, the main meal did not have a bread indicated on the menu. The alternate meal had serving of garlic bread indicated on the menu. A review of the four-week cycle menus and extensions provided by the facility between 8/18/25 and 8/22/25 reflected four ounces of milk was served at lunch and dinner (instead of required eight ounces). It also reflected that each lunch and dinner had two options on the menu, therefore, of 112 meals developed on the menus, 28 included a bread serving. In addition, the menus provided indicated that 26 of 28 dinner meals crackers would be served; however, this was not indicated on the extensions and therefore also not on residents' dinner meal tickets (this translates to what food service staff place on the resident's tray). A review of a three-week cycle menu provided to the surveyor on 8/25/25 by Registered Dietitian (RD) #2, who stated she approved these menus for nutritional adequacy dated 4/9/25, were not the same as the active menus. Of 84 lunch and dinner meal selections, 61 were different from the active menus provided. On 8/21/25 at 10:06 AM, the surveyor interviewed RD #1, in the presence of a second surveyor. She stated that corporate provided the menus and could not speak to who reviewed and approved the menus for nutritional adequacy. On 8/21/25 at 10:37 AM, the Corporate RD (CRD) and the FSD joined the interview. The CRD stated the menus were seasonal and were planned in advance (spring/summer and fall/winter). She also stated that corporate developed the menus; however, she reviewed the choices with the facility RD's and FSD to ensure they would be acceptable to the resident population. The facility preferences were then relayed back to corporate. The CRD could not speak to who reviewed and approved the menus for nutritional adequacy and stated they were based on the Diet Manual. The FSD also stated that she was unaware as to who reviewed and approved the menus for nutritional adequacy. On 8/22/2025 at 12:51 PM, the surveyor interviewed the CRD, FSD, and RD #1, in the presence of the survey team related to menu development and approval. The CRD stated that four ounces of milk was served at lunch and dinner since there was a lot of waste and that resident's were not drinking it. The FSD stated that many trays were returned to the kitchen with unopened milk. The CRD and the FSD could not speak to whether or not they investigated the reason for the unopened milk (dislike verse staff not opening for residents that needed assistance). The CRD acknowledged that the Diet Manual reflected eight ounces of milk (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 315283	If continuation sheet Page 1 of 16

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	implementation and approval was part of the position's responsibilities and duties. NJAC 8:39 - 17.1(b);17.2(a,b);17.4(a(3))		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices and properly store potentially hazardous foods in a safe and sanitary environment to prevent the development of food borne illness. This deficient practice was observed during two kitchen tours and was evidenced by the following: On 8/18/25 at 10:13 AM, the surveyor toured the kitchen with the Food Service Director (FSD), in presence of a second surveyor and observed the following: To the left of the handwashing sink, and to the right of the walk-in freezer, there was a damaged wall with a penetration, which the FSD stated had been that way since she started in May 2025 and the Director of Maintenance (DOM) was aware. The FSD stated that there was no formal communication with the DOM, it was all verbal either one on one, via phone or at morning meeting. She stated there was no logbook and she did not send emails since the DOM did not read his emails. She stated the Licensed Nursing Home Administrator (LNHA) was aware she had outstanding maintenance concerns. In the middle walk-in refrigerator, there was a wood square propped under the metal rack to the left, due to a missing rack leg. The FSD acknowledged the wood was not able to be cleaned and sanitized and stated that the DOM was aware. In the same walk-in refrigerator, there was a black milk crate stored on the metal rack which had a mix of beverages (four-ounce milks, health shakes, and other fluids mixed together). The FSD stated they were left from the tray line meal service and that the staff put the leftovers back in the refrigerator for next use. She acknowledged that this practice could lead to an outdated item if the beverages were not sorted through and use by dates checked one by one before the next meal. Both of the kitchen walk-in refrigerators did not have gaskets on the doors. The FSD stated the DOM was aware. In the dry storage area, there was a hard plastic shelving unit that was flush to the ground without a six inch space between the shelf and the floor. The hoods over the cooking equipment had six lights on each side, which did not work, the FSD stated the DOM was aware. There were double stacked convection ovens that did not work. The FSD stated the DOM was aware. There was a single convection oven that had a heavy buildup of black debris on the bottom and the glass doors had a heavy baked on brown and reddish colored debris. The FSD acknowledged the same and stated it was cleaned once a month. There was a double stacked steamer. Both unit gaskets were in disrepair. The FSD stated the DOM was aware. The top unit had a buildup of black debris on bottom. The FSD acknowledged the same. There was a three-door reach in refrigerator that had been out of service since 8/14/25. The FSD stated the DOM was aware. There were two warming boxes (units that keep cooked food hot), both of which gaskets were in disrepair. The warming box to the right had a buildup of food debris on the bottom which the FSD acknowledged. The handwashing sink in this area had a leaking faucet. The FSD stated the DOM was aware. There were also two food preparation sinks in this area which shared a faucet. The faucet was leaking and the FSD stated that it only provided scalding hot water and that the DOM was aware. There was a top reach in beverage/milk refrigerator that had not been working since the previous Friday. The FSD stated that the DOM was aware. There was a ceiling vent over the ice cream freezer that had fuzzy greyish brown debris hanging down over the freezer and racks of clean inverted coffee mugs. The FSD acknowledged the debris and stated it needed to be cleaned. The dish machine room had multiple missing and cracked floor tiles with still nesting water. There was also a wood block propped under the dish machine table. There were walls to either side of the dish machine in disrepair with penetrations and a build up of back debris on the wall to the right of the dish machine. The FSD stated the DOM was aware of what the surveyor observed. On 8/19/25 at 10:53 AM, a third surveyor interviewed Resident #10, who stated they received expired milk yesterday dated 8/17/25. On 8/22/25 at 9:11 AM, the surveyor interviewed the DOM, in presence of the survey team. He stated that there was no formal communication between himself and the FSD related to maintenance concerns. He stated that the nursing units had logbooks (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	but there was not one for the kitchen. When the surveyor inquired why there was no logbook for the kitchen he stated, "it's been like that for 14 yrs. He stated that when there was something in the kitchen that required maintenance attention, he would fix it on the spot or would order parts if need be. The DOM stated he had no written or formal way of keeping track of any issues brought to his attention from the kitchen or a way to track their resolve. In addition, he stated he was unaware of any maintenance issues in the kitchen prior to the beginning of survey. The DOM stated that he replaced 12 loose tiles in the dish machine area of the kitchen two days ago and was notified of that the night before. He also stated that one of the double stack convection ovens had not been working for over a year due to an electrical issue that was unable to be resolved. On 8/22/25 at 9:47 AM, the third surveyor interviewed Resident #10, who stated they received expired eight-ounce fat free milk at breakfast, dated 8/21/25. The resident stated the Certified Nursing Aide (CNA) confirmed the expiration date. On 8/22/25 at 9:55 AM, the third surveyor interviewed the CNA who verified that the date on the unopened milk carton was 8/21/25. She stated that the kitchen was responsible but that everyone should be checking the tray. In addition, she stated that if expired milk was consumed it could make a resident sick. On 8/22/25 at 2:35 PM, the survey team met with the LNHA, Director of Nursing (DON), Regional Nurse and the [NAME] President (VP) of Clinical Services. The LNHA confirmed that there was no formal way of communicating kitchen maintenance issues to the DOM. He stated concerns were addressed in morning meeting. On 8/25/25 at 10:47 AM, the survey team met with LNHA. He stated that the maintenance concerns identified in the kitchen during survey were addressed, thereby acknowledging there were maintenance concerns. On 8/25/25 at 11:02 AM, the surveyor interviewed the Registered Dietitian (RD) who has worked at the facility for 12 years (four days a week). She stated she conducted informal kitchen rounds every morning and communicated with the FSD related to any concerns she identified. The RD stated prior to a two-week vacation from which she had just returned she was only aware of a three-door reach in refrigerator not working. She stated that there was a logbook in the kitchen to record and track maintenance needs. On 8/25/2025 at 12:04 PM, the RD reapproached the surveyor in the presence of the survey team and stated she was mistaken, and that there was no logbook in the kitchen for maintenance concerns. The RD stated concerns were communicated verbally and at the morning meetings. A review of the facility policy Food Safety and Sanitation with a reviewed date of 2024, reflected the facility would provide safe, nutritious meals in compliance with federal, state and local regulations. It also reflected food would be clean, wholesome and free of spoilage and stock would be rotated using the first in, first out (FIFO) method. A review of an undated facility policy Kitchen Maintenance, reflected food preparation areas should be maintained in a clean, safe and sanitary condition, to prevent food borne illness, accidents and equipment failure. It also reflected the following: Daily Maintenance, included wash and sanitize kitchen equipment used during food preparation. It also included check expiration dates. Weekly Maintenance, included deep clean ovens. Monthly Maintenance, included inspect all kitchen equipment for proper function and safety; perform preventative maintenance on equipment as per manufacturer's instructions; and check sinks for leaks. Documentation, included to keep equipment maintenance records. A review of an undated facility job description for Maintenance Director, included the DOM was responsible for planning, organizing, implementing, and overseeing the total maintenance and repair program of the facility. This included the building, equipment, systems and grounds to ensure the health, safety, comfort and well-being of residents, staff and visitors. This also included routine inspections were completed, documented and corrected. NJAC 8:39-17.1(a); 17.2(g); 31.2(b,c,e)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews and review of pertinent facility documents, it was determined that the facility failed to implement an effective pest control program in the kitchen. This deficient practice was evidenced by the following: On 8/18/25 at 10:13 AM, the surveyor toured the kitchen with the Food Service Director (FSD), in presence of a second surveyor. The surveyors observed a live bug walking up a white tiled wall above a stainless-steel table which had food preparation equipment on it, uncovered. The FSD observed the bug as well and stated, we have a pest control problem here; it was like this when I got here; maintenance is aware; we have a company [name redacted] that comes every Tuesday. The surveyors then observed two live bugs walking on the floor, in the dry storeroom. There were also two glue traps of the floor of the storeroom filled with bugs. During the remainder of the kitchen tour, the surveyors observed damaged walls with penetrations as well as still nesting water where multiple floor tiles were missing in the dish machine area. On 8/22/25 at 9:11 AM, the surveyor interviewed the Director of Maintenance (DOM), in the presence of the survey team. He stated that he had no involvement with pest control and that the Director of Housekeeping (DOH) was responsible to oversee the pest control program. The DOM acknowledged there was pest control problem in the kitchen and added there was a logbook in the kitchen where staff were responsible to note pest sighting (date and location). He further stated that the exterminator would then check those books and treat the targeted areas. The DOM stated the exterminator scheduled a bombing (Bug bombs, also known as foggers or extermination bombs, are canisters of insecticide that disperse a large volume of insect-killing mist when activated. They are used to treat widespread infestations by filling an entire room or area with insecticide) for the kitchen Monday night. On 8/22/25 at 9:25 AM, the surveyor interviewed the DOH, in the presence of the survey team. She stated that she communicated with the exterminator on a regular basis to ensure areas throughout the building where pests were identified would be treated until eradicated. She acknowledged the kitchen had a pest control problem and added the exterminator treated every week. The DOH identified a pest management [name redacted] log sheet and acknowledged that the exterminator wrote no reports in the kitchen each week for June through 8/19/25. She stated that the kitchen staff should have been filling that out when they see a pest in the kitchen to identify the pest and location. She added the sheet is a form of communication to the exterminator, so they would know the areas to treat. The DOH stated about a year or two ago there was an infestation, and the exterminating company had to bomb the kitchen because the exterminator brought to the facility's attention that this larger scale treatment had to be done to contain the problem. She could not speak to why pest control in the kitchen was an ongoing problem; however, she did add that it was damp in the kitchen and roaches like moisture. On 8/22/25 at 2:19 PM, the surveyor interviewed the FSD, in presence of survey team and reviewed the original pest control form for the kitchen. She acknowledged that the kitchen staff were not utilizing the logbook to identify pest sightings for the exterminator. In addition, she could not speak to why the exterminator filled out the staff observations column as no reports. On 8/22/25 at 2:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional Nurse, and the [NAME] President of Clinical Services. The surveyor presented the above concerns. On 8/25/25 at 10:47 AM, the LNHA met with the survey team. He stated that the kitchen would be bombed Tuesday night after the kitchen closed. The LNHA further stated that after the last exterminator visit on 8/19/25 (the day after survey started), the exterminator advised that they needed something stronger. He stated he was made aware of the pests in the kitchen a few months ago, but he thought it was taken care of. On 8/25/25 at 11:02 AM, the surveyor interviewed the Registered Dietitian (RD), in the presence of the survey team. The RD stated she worked four days a week and walked through the kitchen each morning and would report any concerns to the FSD. She stated that she was made aware of a pest control problem in the kitchen a few weeks ago. The RD further stated there was a pest control logbook in the kitchen to identify the (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	date and location of pest sightings so the exterminator would know areas to treat.A review of the [name redacted] Pest Management logbook dated 6/2/25 through 8/19/25 (12 entries), reflected no reports of pest observations in the kitchen. A review of [name redacted] Pest Management Service Inspection Report's dated 6/1/25 through 8/19/25 (12 reports) included a report dated 6/1/25 which reflected, Treated the kitchen for roach activity, reports dated 7/29/25 and 8/5/25 did not include treatment for the kitchen. On 8/19/25, the report included Conducted heavy treatment in the kitchen.A review of an email sent from the [name redacted] Pest Control company to the LNHA dated 8/20/25 at 11:47 AM, reflected We would like to schedule an after-hours intensive cleanout for your kitchen.A review of the facility policy Pest Control dated as reviewed 2024, reflected if pests were seen in the kitchen, the food service manager or appropriate staff should be informed, describing where and when the pest was seen and documented in the log. Appropriate action will be taken to eliminate any reported pest situation in the department. It also reflected the contractor would complete preventative spray treatments and if the problem persisted, the exterminator would use a chemical bomb to destroy the pests. In addition, the policy reflected the extermination company must establish an ongoing preventative program to limit the possible return of such pests.NJAC 8:39 - 31.5(a)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview and review of facility documents, it was determined the facility failed to maintain a comfortable and homelike environment for the residents (Resident #131). This deficient practice was identified on 1of 5 nursing units reviewed for environment and was evidenced by the following:On 8/18/2025 at 11:29 AM, the surveyor observed Resident #131, in the day room. The surveyor observed the resident's room and noted the resident's dresser, with the 3rd drawer down broken. The surveyor observed nails sticking out of the inside of the drawer. On 8/19/2025 at 10:29 AM, the surveyor observed Resident # 131, in a reclining chair, next to their bed. The resident's eyes were closed. The surveyor again noted the dresser with the broken drawer. On 8/20/2025 at 8:50 AM, the surveyor observed Resident # 131, in a reclining chair, in front of the dresser. The resident did not respond to the surveyor's questions. The surveyor again noted the dresser with the broken drawer. The surveyor reviewed the electronic medical record for Resident #131. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; Alzheimer's Disease with late onset (a brain disorder that slowly destroys memory and thinking skills) and Type 2 Diabetes Mellitus without complications (a condition in which the body has trouble controlling blood sugar). A review of the Minimum Data Set (MDS), an assessment tool dated 8/5/2025, revealed the resident had a Brief Interview for Mental Status of 00 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS, revealed the resident was dependent for all activities of daily living. On 8/21/2025 at 8:30 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated she was asked to come in today since the Unit Manager (UM) would not be in. She stated if something was in disrepair or needed to be fixed it would go into the maintenance logbook at the nurse's station. She walked with the surveyor to Resident # 131's room and observed the broken drawer. LPN #1 walked into the room and looked at the drawer. She asked the Certified Nursing Aide (CNA) #1, who was performing Resident #131's care in the room, about the drawer. CNA #1 stated he hadn't noticed it. She acknowledged that it should have been noticed and entered in the maintenance log. LPN # 1 showed the maintenance logbook to the surveyor, which was at the nurse's station. She reviewed, the book with the surveyor, from 6/20/25 and acknowledged that the drawer was not listed there. On 8/21/2025 at 8:45 AM, the surveyor interviewed the Maintenance Director (MD), who stated the first thing he did in the morning was to check all the maintenance log books on the units. He added he also checked with the supervisor to see if there were any issues that were not documented in the books. The MD stated if something was in the book, it would be addressed right then and there. The surveyor showed the MD the picture of Resident #131's broken drawer and he acknowledged the nails sticking out of the wood. He stated he would have expected to be called right away to come fix it. The MD stated he would have addressed it right away, but he had no idea that it was broken. He stated a broken drawer would be addressed right away by removing and replacing the dresser. On 8/21/2025 at 9:02 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated if they (staff) noticed it (something broken), it should be in the maintenance book. The surveyor showed the LNHA the picture of the broken drawer and he acknowledged it should have been noticed especially because the nails were sticking out. The LNHA stated, It should have been addressed right away. He stated the staff had already made him aware of the surveyor's findings. On 8/22/2025 at 2:35 PM in the presence of the survey team, the surveyor made the [NAME] President of Clinical, the LNHA, the Regional Nurse and the Director of Nursing aware of the above findings.NJAC 8:39-4.1(a)		

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NAME OF PROVIDER OR SUPPLIER South Mountain Hc		STREET ADDRESS, CITY, STATE, ZIP CODE 2385 Springfield Avenue Vauxhall, NJ 07088	
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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, it was determined that the facility failed to ensure that an air mattress (designed to prevent and treat pressure wounds) was accurately set in accordance with the resident's weight for one (1) of one (1) resident reviewed for pressure ulcers, Resident #172. This deficient practice was evidenced as follows: On 8/19/2025 at 10:39 AM, the surveyor interviewed Resident #172, who was in bed. The surveyor observed an air mattress pump at the foot of the resident's bed. The setting on the pump was set at approximately 360. The resident stated, All I know is the pump is for the air mattress because I have a wound. On 8/20/2025 at 8:45 AM, the surveyor observed the resident in bed with the air mattress pump set at approximately 360. The survey met with resident's nurse to attempt to do a wound care observation, but the nurse stated the wound care was done this morning by the wound care team. The surveyor reviewed the electronic medical record (EMR) for Resident #172. A review of the admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; chronic diastolic (congestive) heart failure (the left ventricle has become stiffer than usual, and the heart can't relax the way it should, which could cause shortness of breath) and adjustment disorder with depressed mood (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities). A review of the quarterly Minimum Data Set, an assessment tool dated 5/8/2025, revealed the resident had a Brief Interview for Mental Status of 15 out of 15, indicating the resident was cognitively intact. A review of the individual comprehensive care plan revealed a focus of has hx (history) of refusing incontinent care, refusing to go to bed at night. Date Initiated: 07/01/2024. Further review, revealed a focus of at risk for skin breakdown r/t fragile skin, PVD (peripheral vascular disease- a circulatory disorder that results from narrowed blood vessels, leading to reduced blood flow, primarily affecting the legs and feet), impaired mobility, incontinence, Hx: skin impairment, revision on: 12/20/2024 with an intervention that included utilize pressure relieving cushion to chair, LAL (low air loss) mattress to bed, revision on 3/21/2025. A review of the Order Summary Report revealed a physician's order (PO) for Air mattress on bed for pressure prevention every shift for Pressure Prevention Check setting and function on air mattress Start Date 3/28/2024 at 1500 (3PM). A review of the Treatment Administration Record (TAR) for August 2025 revealed the above PO had been signed as completed for day shift on 8/19/2025 and 8/20/2025. On 8/22/2025 at 10:07 AM, the surveyor observed with Licensed Practical Nurse (LPN) #1, Registered Nurse (RN) #1, and Certified Nursing Assistant (CNA #1). At the beginning of the observation, LPN #1 had bumped the air mattress pump and knocked it off the bed. The nurse picked the pump up and placed it back on the bed. The surveyor observed the setting remained on approximately 360, the same setting as the prior observations. After the wound care observation was completed, the surveyor questioned the air mattress pump. Both RN #1 and LPN #1, confirmed the air mattress setting was at 360. On 8/22/2025 at 10:33 AM, the surveyor interviewed CNA #1, who stated the air mattress was set by resident's weight and the nurses checked it. On 8/22/2025 at 10:35 AM, the surveyor interviewed LPN #1, who stated she rounded with the wound care team. The surveyor asked about the air mattress setting of 360, LPN #1 stated it probably got messed up when the pump fell. The surveyor made her aware of the above observations and that the settings had been the same prior to the pump falling. She stated the pump should be set close to the resident's weight. She checked the electronic medical record in the presence of the surveyor and verified the resident's weight was 259 pounds. She stated the higher setting would make the mattress too hard. LPN #1 stated the reason it was important to have the settings set to the resident's weight was for wound prevention or healing, so it (the mattress) could adjust to the weight. On 8/22/2025 at 10:45 AM, the surveyor interviewed CNA #2, who stated, We check to make sure there is air in there if not, we call maintenance. On 8/22/2025 at 11:17 AM, the surveyor interviewed RN #1, who was Resident #127's assigned nurse. RN #1 stated she makes sure the air mattress was working but she was not checking (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the settings. RN #1 reviewed the TAR in the presence of the surveyor and acknowledged she had signed the above-mentioned PO as being completed but then confirmed she signed that it was working. On 8/22/2025 at 11:21 AM, the surveyor interviewed the Director of Nursing (DON), who stated the purpose of an air mattress was prevention of stage 3 and 4 pressure ulcers. She stated maintenance applied the air mattress and sets it. The DON stated maintenance would ask for the weights and set the pump. She added it was between the nurses and the unit managers to check that the weight setting was correct. On 8/22/2025 at 1:27 PM, the DON, in the presence of another surveyor, confirmed that the facility does not have a policy on the air mattress settings. She stated the setting should be adjusted to the resident's weight due to weight distribution and added we are in servicing all the nurses on checking the settings. On 8/22/2025 at 2:35 PM in the presence of the survey team, the surveyor made the [NAME] President of Clinical, the Licensed Nursing Home Administrator, the regional nurse and the DON were made aware of the above findings. A review of the facility's policy, Homelike Environment Policy revised 1/1/2025, revealed Policy: The facility is committed to creating and maintaining a homelike environment by: Ensuring the environment is free from odors, clutter, and hazards while maintaining a warm and inviting atmosphere. Procedures: 3. Maintenance Services: Maintenance staff will ensure all resident rooms and common areas are kept in good repair, with no hazards such as loose flooring, exposed wiring, or broken furniture. 6. Staff Training: Housekeeping and maintenance staff will be trained in infection prevention, safety, with emphasis on respecting resident preferences and maintaining a homelike environment. NJAC 8:39-25.2 (c), 27.1(e)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in one (1) of six (6) residents (Resident #202) observed during the medication observation pass. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 8/19/25 at 8:54 AM, during the medication administration observation, the surveyor observed Registered Nurse (RN#1) enter the room of Resident #202. The surveyor observed RN#1 informing Resident #202 that she would be taking the resident's vitals and would then be administering the resident's medications. RN #1 was observed taking the resident's vitals which were blood pressure 167/59, heart rate (HR) 67. On 08/19/25 at 8:57 AM, the surveyor observed RN#1 preparing to administer five (5) medications to Resident #202 which included Metoprolol Tartrate 50 mg tablet (medication for lowering blood pressure), Depakote 250 mg extended-release tablets (medication for seizures), Hydralazine 50 mg tablet (medication for lowering blood pressure), Buspar 5mg tablet (medication for anxiety), and Norvasc 5mg tablet (a medication for lowering blood pressure). After RN#1 finished preparing the resident's medication she was observed entering the resident's room and administering Resident #202's medications. After RN#1 finished administering Resident #202's medications, the surveyor observed RN#1 signing off the Electronic Medication Administration Record (e-MAR) but did not observe her entering the vitals for the Metoprolol Tartrate 50mg, Hydralazine 50 mg, or Norvasc 5 mg tablets. After completing medication administration observation, the surveyor did record review which revealed that the resident had parameter orders for Metoprolol, Hydralazine, and Norvasc which included a hold order if the Systolic Blood Pressure (SBP) (the pressure in the arteries when the heart contracts and pumps blood throughout the body) or the Heart Rate (HR) fell below a certain level. A review of the full medical record revealed no documentation of the resident's Blood Pressure which included the SBP. A review of the admission Record (an admission summary) reflected that Resident #16 was admitted to the facility with diagnoses that included but not limited to; hypertension (a condition in which the force of the blood against the artery walls is too high), hypertensive heart disease without heart failure (heart damage caused by long-term high blood pressure), and hypertensive urgency (a condition of a very high blood pressure reading (such as over 180/120) without any signs of acute organ damage like chest pain shortness of breath, or vision changes). A review of the August 2025 Order Summary Report (OSR) revealed the following PO's dated 08/12/25: 1. Hydralazine tablet 50 mg, give 1 tablet by mouth two times a day B/P (blood pressure) hold SBP less than 110 per policy. May cause dizziness/increase photosensitivity. 2. Metoprolol Tartrate tablet 50 mg, give 1 tablet by mouth two times a day B/P hold SBP less than 90, and pulse hold HR less than 60 per policy. Take with or immediately after meals. May cause dizziness. May cause orthostatic hypotension. 3. Norvasc tablet 5 mg (Amlodipine besylate), give 1 tablet by mouth (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two times a day B/P hold SBP less than 110 and pulse per policy. May cause dizziness/lightheadedness. Avoid grapefruit.A review of the August 2025 e-MAR revealed the following POs dated 8/12/25:1.Hydralazine tablet 50 mg, give 1 tablet by mouth two times a day B/P (blood pressure) hold SBP less than 110 per policy. May cause dizziness/increase photosensitivity with an administration time of 0900 (09:00 AM) and 1700 (5:00 PM). A further review of the e-MAR revealed that nurses were not plotting the B/P (which included the SBP) or HR.2.Metoprolol Tartrate tablet 50 mg, give 1 tablet by mouth two times a day B/P hold SBP less than 90, and pulse hold HR less than 60 per policy. Take with or immediately after meals. May cause dizziness. May cause orthostatic hypotension with an administration time of 0900 (9:00 AM) and 1700 (05:00 PM). A further review of the e-MAR revealed that nurses were not plotting the B/P or HR.3.Norvasc tablet 5 mg (Amlodipine besylate), give 1 tablet by mouth two times a day B/P hold SBP less than 110 and pulse per policy. May cause dizziness/lightheadedness. Avoid grapefruit with an administration time of 0900 (9:00 AM) and 1700 (05:00 PM). A further review of the e-MAR revealed that nurses were not plotting the B/P or HR. On 8/19/25 at 11:00 AM, the surveyor interviewed RN#1, who stated that she would take the resident's vitals which included the BP and HR and will write it down on a piece of paper. RN#1 acknowledge that she does not enter the vitals into the electronic medical record. In the presence of the surveyor, RN#1 reviewed Resident #202's e-MAR and acknowledged that the resident had three medication that required parameters which included Hydralazine 50 mg, Metoprolol Tartrate 50 mg, and Norvasc 5 mg and that the e-MAR contained no place to document the resident's vitals. She further acknowledges that medications that have perimeters should contained a place to plot the BP and HR. She stated that all three medications did not contain a place to plot the BP and HR.On 08/19/25 at 1:00 PM, the surveyor discussed the above concerns with the facility administration team that consisted of the Licensed Nursing Home Administrator (LNHA) and the Regional Director of Nursing. There was no additional information provided.A review of the facility's policy for Medication Administration that was dated 11/2024 and was provided by the Regional Director of Nursing revealed the following:The policy does not mentioned perimeters but mentions to review the eMAR and notified the physician if something was questionable. If an order for a medication is unusual (such a large dose more than two tablets will be required), question the order. Check the physician order sheet (POS) against the eMAR. Compare the eMAR to the label on the drug container. Call the physician or pharmacist with any concerns.NJAC 8:39-11.2 (b), 29.2 (d)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the morning medication administration observation on 8/19/25, the surveyor observed four (4) nurses administer medications to six (6) residents. There were 27 opportunities, and two (2) errors were observed which calculated to a medication administration error rate of 7.41%. The deficient practice was identified for two (2) of six (6) residents, (Resident #55 and #74), that were administered medications by two (2) of four (4) nurses that were observed. The deficient practices were evidenced by the following: 1. On 8/19/25 at 8:32 AM, during the medication administration observation, the surveyor observed Licensed Practical Nurse (LPN#1) entered the room of Resident #55. The surveyor observed LPN#1 informing Resident #55 that she would be administering the resident's medications. The surveyor observed the resident who was in their bed and was observed eating breakfast. On 8/19/25 at 8:35 AM, the surveyor observed LPN#1 preparing to administer five (5) medications to Resident #16, which included 15 ml of Potassium Chloride 20 MEQ/15 ml solution (low potassium levels), one (1) tablet Carvedilol 3.125 mg (medication for lowering blood pressure), one (1) tablet of Torsemide 20 mg, three (3) tablets of Colace 100 mg (medication for constipation), and one (1) tablet of Norvasc 5 mg (medication for lowering blood pressure). While preparing the resident's medications the surveyor observed LPN#1 reviewing the resident's Electronic Medication Administration Record (e-MAR), the surveyor noticed that LPN#1 did not click and read the full directions for Potassium Chloride 20 MEQ/15 ml solution (ERROR #1). LPN#1 told the surveyor that the resident received their Potassium liquid whole, the surveyor then observed LPN #1 entered the resident's room and administered the resident's medication including Potassium Chloride 20 MEQ/15 ml solution. The resident was observed drinking approximately 60 ml of water after being administered their Potassium liquid. A review of the admission Record (an admission summary) reflected that Resident #55 was admitted to the facility with diagnoses that included but not limited to; hypertension (a condition in which the force of the blood against the artery walls is too high), hypokalemia (low potassium), and chronic diastolic (congestive) heart failure (occurs when the heart's lower left chamber (left ventricle) becomes stiff and doesn't fill with blood properly during heart relaxation rate. A review of the annual Minimum Data Set, an assessment tool used to facilitate the of care, dated 06/18/25, reflected that the resident's cognitive skills for daily decision-making score was 11 out of 15, which indicated that the resident's cognition was mildly impaired. A review of the August 2025 Order Summary Report (OSR) revealed a Physician's Order dated 06/30/25, for Potassium Chloride solution 20 MEQ/15 ml (10%), give 15 ml by mouth two times a day for hypokalemia. 15 ml=20 MEQ dilute every 15 ml with at least 90 ml (3 ounces) of fluid. Administer with or after meals. A review of the August 2025 e-MAR revealed a Physician's Order dated 06/30/25, for Potassium Chloride solution 20 MEQ/15 ml (10%), give 15 ml by mouth two times a day for hypokalemia. 15 ml=20 MEQ dilute every 15 ml with at least 90 ml (3 ounces) of fluid. Administer with or after meals with an administration time of 0900 (09:00 AM) and 1700 (05:00 PM). A review of the Manufacturer's Specifications for Potassium Chloride 20 MEQ/15ml solution revealed the following: -Dilute the solution: Pour the measured liquid dose into a glass with at least 4 ounces (1/2 cup) of water or juice. Cold liquid can also help mask the unpleasant taste. On 8/19/25 at 11:00 AM, the surveyor interviewed Resident #55 who acknowledge that they always received their Potassium in a little medicine cup and that it was never administered diluted in a cup of water. Resident #55 stated that they never experience any stomach or throat irritation taking the medication whole and undiluted. On 8/19/25 at 11:20 AM, the surveyor in the presence of LPN #1, reviewed Resident #55's e-MAR. LPN#1 reviewed the directions for Resident #55's Potassium Chloride Solution and acknowledged that there was an order to dilute the Potassium solution with 90 ml of water. LPN#1 further acknowledge that she should have diluted the medication prior to administering the medication. 2. On 8/19/25 at 09:16 AM, during the medication administration (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation, the surveyor observed Registered Nurse (RN#1) entered the room of Resident #74. The surveyor observed RN#1 identify Resident #74 and then observed RN#1 taking the resident's vitals. RN#1 then informed Resident #74 that she would be administering the resident's medications. On 08/19/25 at 9:20 AM, the surveyor observed LPN#1 preparing to administer five (5) medications to Resident #74, which included one tablet of Carvedilol 12.5 mg (medication for lowering blood pressure), one tablet of Hydralazine 50 mg tablet (medication for lowering blood pressure), one tablet of Aspirin 81 mg chewable tablet (order was for Aspirin 81 mg enteric-coated tablet which is a special coating that allow the medication to be dissolve in the small intestine, which protects the stomach from experiencing discomfort)(coronary artery disease) ERROR #2, Norvasc 10 mg (medication for lowering blood pressure) and Apixaban 5 mg (coronary artery disease). The surveyor observed RN#1, after preparing the above medications, fill a cup with approximately 120 ml of water and was observed her walking into Resident #74's room. Once RN#1 entered the room, she was stopped by the surveyor, just prior to administering the resident's medications. The surveyor asked the nurse to leave the resident's room with the resident's medications. The surveyor, in the presence of RN#1, reviewed the resident's e-MAR. At that time, RN#1 acknowledge that the resident had an order for Aspirin enteric coated 81 mg tablets. She further acknowledges that she picked the wrong form of Aspirin. When the surveyor asked her why enteric coated Aspirin was different from regular chewable Aspirin, RN#1 was not able to tell the surveyor the difference between the two Aspirin's. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; hypertension (a condition in which the force of the blood against the artery walls is too high), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete painful blockage). A review of the Annual Minimum Data Set, an assessment tool used to facilitate the management of care dated 07/14/25, reflected that the resident's cognitive skills for daily decision-making score was 11 out of 15, which indicated that the resident had mild cognitive impairment. A review of the August 2025 OSR revealed a PO dated 07/08/25, for Aspirin EC low dose tablet delayed release 81 mg (Aspirin), give one tablet for CAD (coronary artery disease). Do not crush/chew. Give with plenty of water. Monitor for sign of bleeding, bruising, dark urine, and tarry stools. A review of the August 2025 e-MAR revealed a PO dated 07/08/25, for Aspirin EC low dose tablet delayed release 81 mg (Aspirin), give one tablet for CAD (coronary artery disease). Do not crush/chew. Give with plenty of water. Monitor for sign of bleeding, bruising, dark urine, and tarry stools with an administration time of 0900 (9:00 AM). On 8/19/25 at 1:10 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator (LNHA) and the Regional Director of Nursing. No further information was provided. A review of the facility's policy for Medication Administration that was dated 11/2024 and was provided by the Regional Director of Nursing revealed the following: Under Medication Pass: Read medication name, dosage, and timing. Read labels on all medications three times: before removing from cart/before pouring it/ and after pouring it. NJAC 8:39-11.2(b), 29.2(a)(d)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, it was determined that the facility failed to properly secure medications in one (1) of four (4) medication carts observed during Medication Administration Pass. This deficient practice was evidenced by the following: On 8/19/25 at 09:16 AM, during the medication administration observation, the surveyor observed Registered Nurse (RN#1) enter the room of Resident #74. The surveyor observed RN#1 identify Resident #74 and then observed RN#1 taking the resident's vitals. RN#1 then informed Resident #74 that she would be administering the resident's medications. On 08/19/25 at 9:20 AM, the surveyor observed LPN#1 preparing to administer five (5) medications to Resident #74, which included Carvedilol 12.5 mg (medication for lowering blood pressure), Hydralazine 50 mg tablet (medication for lowering blood pressure), Aspirin EC (enteric-coated tablet which is a special coating that allow the medication to be dissolve in the small intestine, which protects the stomach from experiencing discomfort) 81 mg (coronary artery disease), Norvasc 10 mg (medication for lowering blood pressure) and Apixaban 5 mg (coronary artery disease). The surveyor observed RN#1, after preparing the above medications, fill a cup with approximately 120 ml of water. The surveyor observed RN #1 walk into Resident #74's room without locking the medication cart. The surveyor observed no residents in the vicinity of the medication cart. Once RN#1 entered the room, the surveyor stopped her just prior to administering the resident's medications. The surveyor asked the nurse to leave the resident's room with the resident's medications. The surveyor stopped RN#1 because she was going to administer the wrong form of Aspirin (non-enteric coated). At that time, the surveyor asked RN#1 if her medication cart was locked, in which she replied no. RN#1 acknowledged that she should have locked the medication prior to leaving the medication cart and entering the resident's room. On 8/19/25 at 1:00 PM, the surveyor presented the above concerns to the Regional Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). No further information was provided. A review of the facility's policy for Medication Storage that was dated 12/2024 and was provided by the Regional DON indicated the following: A. with the exception of Emergency Drug Kits, all medications will be stored in a locked cabinet, cart or medication room that is accessible only to authorized personnel, as defined by facility policy. A review of the facility's policy for Medication Administration that was dated 11/2024 and was provided by the Regional DON indicated the following: Keep the med cart visible or locked at all times while passing medications. NJAC: 8:39-29.4 (a) (h) (d)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/25/2025
NAME OF PROVIDER OR SUPPLIER South Mountain Hc		STREET ADDRESS, CITY, STATE, ZIP CODE 2385 Springfield Avenue Vauxhall, NJ 07088	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and a review of pertinent medical records, it was determined that the facility failed to minimize the potential spread of infection to residents during medication administration for 1 of 4 nurses observed during medication pass on 1 of 4 nursing units. This deficient practice was evidenced by the following. On 08/19/25 at 8:34 AM, during medication administration observation the surveyor observed a Registered Nurse (RN#1) taking Resident #202's Blood Pressure (BP) with a blood pressure monitor. After taking Resident #202's BP the nurse was observed taking the BP monitor (without sanitizing) and placing it next to her medication cart. RN#1 was then observed preparing Resident #202's medications (no observation of performing hand hygiene) and was then observed entering the resident's room. The surveyor observed RN#1 lifting the resident's head of bed with a bed remote control, which was next to the resident's bed. RN#1 was then observed handling Resident #202's pillows and placing it behind the resident's back. After administering Resident #202's medications the surveyor observed RN#1 returning to her medication cart, without performing hand hygiene and signing off Resident #202's Electronic Medication Administration Record (e-MAR). After signing off the e-MAR for Resident #202's, the surveyor observed RN#1, without performing hand hygiene or disinfecting the BP monitor, take the BP monitor and enter Resident #74's room. The surveyor stopped RN#1 just before she was going to take Resident #74's BP. The surveyor asked RN#1 to step out of the resident's room with the BP monitor. At that time, the surveyor interviewed RN#1, who acknowledge that she did not perform hand hygiene or disinfect the BP monitor. RN#1 further stated that she should have disinfected the BP monitor after taking Resident 202's vitals and that she should have performed hand hygiene after administering Resident #202's medications. The surveyor then observed RN#1 wash her hands. RN#1 was observed putting on the faucet, wetting her hands, applying soap, and then scrubbing her hands for 5 seconds away from the stream of water and then rinsing her hands with the stream of water. At that time, the surveyor asked RN#1, how many seconds should she scrub her hands away from a stream of water, the RN#1 stated for 20 second. The surveyor then asked RN#1 if she scrubbed her hands away from a stream of water for 20 seconds, RN#1 stated No. On 8/19/25 at 1:00 PM, the surveyor presented the above concerns to the Licensed Nursing Home Administrator and the Regional Director of Nursing. No further information was provided. A review of the facility's policy titled Medication Administration with a review date of 11/2024 and was provided by the Regional Director of Nursing revealed the following: Wash hands before and after resident contact. An alcohol-based commercial may be substituted. A review of the facility's policy titled Hand Washing/Hand Hygiene with a review date of 04/28/25 and was provided by the Regional Director of Nursing revealed the following: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-microbial) and water for the following situations: c. Before preparing or handling medications. Under Washing Hands: 1. Vigorously later hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under moderate stream of running water, at comfortable temperature. Hot water is unnecessarily rough on hands. A review of the facility's policy titled Cleaning and Disinfecting Equipment Between Residents. with a review date of 4/15/25 and was provided by the Regional Director of Nursing revealed the following: To provide maximum safety and prevent transmission of pathogenic microorganisms from one resident to another, this facility will ensure that measures are in place to clean and disinfect all equipment that come in contact with the resident prior to the use of another resident. NJAC 8:39-19.4 (a)(1), (m)		