STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315384	A. BUILDING _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE MOUNTAIN CARE CENTER	ROUTE 1 & 18 NEW BRUNSWICK, NJ 08901

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F 000	INITIAL COMMENTS Complaint # NJ00151843, NJ00162232 Census: 93 Sample Size: 4 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		6/9/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/01/2023

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F 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: NJ00162232 Based on interviews and a review of the medical records (MRs) and other facility documentation on 5/3/23, it was determined that the facility staff failed to immediately report an injury of unknown origin to the facility Administration as required and according to the facility's policy for 1 of 3 sampled residents (Resident #2) reviewed for abuse. This deficient practice is evidenced by the following: 1. According to the Admission Record, Resident #2 was admitted to the facility on [redacted] with diagnoses which included but were not limited to: [redacted] and EX. Order 26.(4) B1 A Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated EX. Order 26.(4) B1 and the resident required assistance with activities of daily living (ADLs). A review of a care plan (CP) revised on [redacted] included that Resident #2 was at risk for [redacted]. Interventions included but were not limited to [redacted] to wheelchair, monitor skin daily during care and report changes to the nurse, and weekly nursing [redacted] assessment. The Order Summary Report (OSR) included a Physician Order (PO) for weekly skin checks.	F 609	Element One: LPN#1 re-inserviced immediately on reporting of any injury of unknown origin when informed of finding by surveyor. Resident# 2 was assessed and incident was investigated immediately and abuse was ruled out. The Staff received re-education on reporting any injury of unknown origin to the facility administration immediately of its finding. Element Two: all resident have potential to be affected by this deficient practice. The facility's DON and Assistant Director of Nurses (ADON) conducted audits on all resident who have the potential to be affected by this deficient practice. The audits revealed no other injury of unknown origin noted or reported. Element Three: The Staff received re-education on reporting any injury of unknown origin to the facility administration immediately of its finding. The facility's Administrator, DON and ADONwill review the 24 hours report during daily meeting with the multidisciplinary team and any allegations or notes reflecting any injuries of unknown origin are found. It will be reviewed, investigated and reported to the	

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F 609	Continued From page 2 A review of the medication administration record (MAR) revealed a PO for a weekly skin check, but it was generated as unscheduled. It was clarified during a telephone interview with the Director of Nursing (DON) on 5/4/23 at 11:30 AM and 5/16/23 at 10:00 AM that nurses complete the shower weekly EX. Order assessment form instead of documenting it in the MAR. The "weekly shower skin assessment," document dated EX. Order 26.(4), signed by the Licensed Practical Nurse (LPN) #1 and Certified Nursing Assistant (CNA) #1, revealed that Resident #2 had no skin EX. Order 26.(4) B1 or open areas. According to the shower schedule, the resident was scheduled for a shower twice a week. However, the facility was unable to provide additional documentation of the weekly shower assessments for EX. Order and EX. Order 26.(4) B1 On 5/3/23 at 10:40 AM, the surveyor, in the presence of another surveyor and LPN #1, observed Resident #2 in bed. The surveyor observed a EX. Order 26.(4) B1 to the EX. Or approximately EX. Order 26.(4) B1. LPN #1 stated that the EX. Order 26.(4) B1 had "always been there." The surveyor was unable to interview Resident #2 due to EX. Order 26.(4) B1. The surveyor observed and discussed Resident #2's EX. Order 26.(4) B1 to the EX. Order 26.(4) B1 with the DON and Administrator on 5/3/23 at 4:34 PM. They confirmed that they were not aware of the EX. Order 26.(4) B1 On 5/4/23 at 10:59 AM post survey, the surveyor received an investigation summary document	F 609	appropriate agency. Element Four: The facility DON/ADON/Designee will monitor daily reports for 4 weeks then weekly times two months for any allegation of injury of unknow origin.The results of its findings will be acted upon immediately, investigated and reported to regulatory agencies. Results of audits will be presented to QAPI team monthly for review and	

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from the Administrator. The document was dated EX. Order 26.(4) B1 completed by the Administrator which revealed a conclusion and resolution that the EX. Order 26.(4) B1 noted on Resident #2's EX. Order 26.(4) B1 was due to the resident routinely resting the EX. Order 26.(4) B1 on the dining table.

A review of a document attached to the investigation summary, titled "body check," a skin assessment form dated EX. Order 26.(4) included an "EX. Order 26.(4) B1.

A review of a CP attached to the investigation summary, initiated on EX. Order 26.(4), included that Resident #2 had an alteration in EX. Order 26.(4) B1 related to placing EX. Order 26.(4) B1 on the dining room table. Interventions included but were not limited to: Place EX. Order 26.(4) B1 between EX. Order 26.(4) B1 and table. Assess for signs/symptoms of infection and notify the physician for redness, warmth, changes in vital signs, or resident's status.

During an interview with the surveyor on 5/3/23 at 1:32 PM and a telephone interview on 5/4/23 at 1:35 PM, LPN #1 explained that the skin EX. Order 26.(4) B1 on Resident #2's EX. Order 26.(4) B1 had always been there, and he was unable to remember when he first noticed it. LPN #1 further explained that he would report any injury of unknown origin to the supervisor, DON, Assistant DON (ADON), or Administration. However, LPN #1 confirmed he never reported Resident #2's skin EX. Order 26.(4) B1 to the administration staff because the resident was always EX. Order 26.(4) B1 and rested his/her EX. Order 2 on the dining table; therefore, it was not an injury of unknown origin.

During a telephone interview with the surveyor on 5/4/23 at 11:30 AM, the ADON stated that CNAs

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and nurses should report any skin [EX. Order 26.(4) B1] such as [EX. Order 26.(4) B1], so that the administration staff could investigate further.

During an interview with the surveyor on 5/3/23 at 4:34 PM and a telephone interview on 5/4/23 at 11:30 AM, and 5/16/23 at 10:00 AM, the DON stated that CNAs and nurses are expected to report any skin [EX. Order 26.(4) B1], such as [EXEX. Order 26], noted during skin checks to the administration staff. She further stated that nurses are required to conduct [EX. Orde] assessments during shower days and complete the weekly shower [EX. Orde] assessment. She acknowledged that the weekly shower [EX. Order] assessment forms should have been completed as scheduled. Additionally, LPN #1 should have reported the skin [EX. Order 26.(4) B1] to the administration staff to be investigated further.

A review of the facility's policy titled "Prohibition of Resident Abuse & Neglect" dated 6/18/22, included but was not limited to: "1. Any witnessed, alleged, or suspected violations involving mistreatment ...including injuries of unknown source ...MUST BE REPORTED IMMEDIATELY TO THE EMPLOYEE SUPERVISOR. 2. The supervisor must immediately notify the Administrator and/or the DON. 3. Abuse Allegations (abuse ...includes injuries of unknown source) will be REPORTED IMMEDIATELY to the appropriate authorities by the Administrator and/or Director of Nursing. "

NJAC 8:39-9.4(f)