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 09/28/2023

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

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaints#: NJ00166566, NJ00166567, NJ00166296, NJ00165848, NJ00165869, and NJ00164042 Survey Date: 9/28/23 Census: 91 Sample: 19 (sample) + 3 (Closed Records) + 13= 35 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 557 SS=E	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by:	F 557		10/12/23

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

Electronically Signed | 10/13/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 557	Continued From page 1 Based on observation, interview, and review of pertinent facility documentation it was determined that the facility failed to treat all residents in a dignified manner. This deficient practice occurred for two (2) of four (4) residents reviewed for dignity (Resident #14 and #67) and was evidenced by the following: On 9/20/23 at 10:25 AM, the surveyor met with Residents #8, #14, #27, and #67 for the Resident Council meeting (RCm) in a closed-door meeting. During the RCm, the surveyor followed the probes (the process of asking questions and examining facts in a situation) in the survey process, in question #18 for if resident rights were being respected in a dignified manner, Residents #14 and #67 both claimed they were not. On that same date and time, both residents informed the surveyor that staff at times do not knock before entering their room. Resident #14 stated that he/she was unable to remember the name of the staff and that it happened a few times on both morning and afternoon shifts. At that time, a staff wearing a green scrub (the sanitary clothing worn by physicians, nurses, and other workers involved in patient care) entered the door, walked straight through the room without notifying the residents and the surveyor of the staff purpose. The surveyor greeted the staff, the staff did not respond, and later on the staff left after going to another room that was inside the room where the RCm was being conducted. Then, Resident #14 stated that the staff who entered the room was a nurse and the same staff the resident was talking about who entered the resident's room without knocking. Resident #14 further stated "I remembered her (the nurse)," but	F 557	Element One - Corrective Action: It is the practice of the Center to ensure that all residents are treated with dignity and respect, including knocking on doors before entering rooms, introducing themselves, and stating reasons for entering. All, staff, including those that were involved in the deficient practice, were immediately educated on treating residents with dignity and respect, including knocking on doors before entering rooms. Element Two - Identification of at-Risk Residents: This standard was not met for Residents #14 and #67. All residents that have doors have the potential of being affected. Element Three - Systemic Change: Staff, including those that were involved in this deficient practice, were immediately educated on treating residents with dignity and respect, including knocking on doors before entering rooms. Staff will be educated twice a year and as needed on dignity and respect. An audit was started immediately by the Administrator/Designee to ensure that staff are knocking on doors before entering resident rooms, introducing themselves, and stating reasons for entering. A random audit of five rooms will be conducted weekly for one month and then twice monthly for two months and concerns to be addressed and staff to be educated immediately as discovered. Element Four - Quality Assurance:	

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F 557	Continued From page 2 was unable to remember the name. Furthermore, at that same time, during the RCm, another staff entered the room without first knocking and did not explain the purpose of why she entered the room. The Recreation Aide (RA) stated that she works in the activity department and wanted to get an activity supply after the surveyor's inquiry, and then the RA left. On 9/20/23 at 11:07 AM, after the RCm ended, at the door was the Activity Director (AD). The surveyor notified the AD of the above concerns regarding the RA who did not knock prior to entering a closed room meeting, and the AD provided the RA's name. On that same date and time, the Director of Nursing (DON) joined the AD. The surveyor notified the DON of the same concern and the surveyor asked the DON the name of the nurse who did not knock prior to entering the closed-door meeting room. The DON stated that she will get back to the surveyor. On 9/20/23 at 11:22 AM, the surveyor went to the [redacted] wing unit and found the nurse who entered the room during the RCm. The Licensed Practical Nurse (LPN) acknowledged that she was the nurse who did not knock before entering the closed-door meeting room. The LPN stated that when she saw there was a meeting ongoing in the room she thought that it was "just" a regular meeting within the facility of residents and staff and she did not realize that it was the surveyor who was inside the room not until she was inside the room already. At that time, the LPN informed the surveyor that	F 557	Results will be reported monthly to the QAPI team for review and revised as necessary, utilizing the Guardian Angel Rounds Sheet. Guardian Angel Rounds management reporting sheets are reviewed weekly in morning meetings. A random room-knocking audit of five rooms will be completed by the administrator weekly for one month and then twice monthly for two months. Corrections will be addressed as they are discovered. Results are to be reported monthly times 12 months to the quality assurance performance team for review and revision as necessary.	

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F 557	Continued From page 3 she went inside the room to talk to the therapist (Rehabilitation staff) regarding her one resident. The LPN further stated "I'm sorry," and that she realized afterward what she did, and that she should have knocked first before entering the room. A review of Resident #14's most recent annual Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 8/10/23, showed in Section C Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that resident's cognitive status was [redacted]. A review of Resident #67's aMDS with an ARD of 9/07/23 in Section C a BIMS score of [redacted] which reflected that the resident's cognition was [redacted]. On 9/22/23 at 10:07 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON, and the surveyor notified the facility management of the above findings. On 9/25/23 at 10:35 AM, the survey team met with the LNHA and the DON. The LNHA stated that the staff should have knocked first and waited to be accepted to enter, and explain what they were supposed to do, and "that's our standard practice." A review of the facility's Resident Rights Policy that was provided by the LNHA, with a revised dated August 2009 included that employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: #3. Our facility will make every effort to assist each resident in exercising his/her rights to	F 557		

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F 557	Continued From page 4 assure that the resident is always treated with respect, kindness, and dignity. NJAC 8:39-4.1 (a)(12)	F 557		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		10/12/23

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F 584	Continued From page 5 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint# NJ00166296 Based on observation, interview, and review of pertinent facility documentation, it was identified that the facility failed to provide the residents with a safe, comfortable, clean, and homelike environment. This deficient practice was identified in a) one (1) of three (3) residents, (Resident #142) reviewed for environment concerns, b) the dining, and c) the laundry area observed and reviewed for a clean, comfortable, and homelike environment of residents. This deficient practice was evidenced by the following: 1. The surveyor reviewed Resident #142's medical records. The Admission Record (or face sheet; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted]	F 584	Element One - Corrective Action: It is the practice of the Center to ensure that all residents reside in a safe, clean, homelike environment. All areas of concern were immediately cleaned. The fan was immediately cleaned, and the clothing on the donation rack was immediately covered. The clothing rack was immediately dusted and painted. The folding table was removed and replaced. The plastic divider curtain was replaced. All items of concern were removed. All broken toilet paper holders were removed and replaced. Resident #142 was discharged from the facility. Housekeepers were immediately re-educated on high dusting and cleaning other elements in the resident rooms and dining room. Element Two - Identification of at-Risk Residents: All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: Laundry staff was immediately educated on properly handling and storing clean clothing and personal items. In addition,	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 584	Continued From page 6 Ex Order 26. 4B1 [redacted]. The admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 8/02/23 showed a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognitive status was [redacted]. A review of the 8/07/23 at 10:39 AM phone interview of another surveyor with the resident's Responsible Party (RP) revealed that according to the RP (also known as the caller), the resident's room was dusty, dirty, looked like not been cleaned in weeks, the air conditioner blows dust, and sheets not changed. The RP further stated that on 8/06/23 found clothes with feces in the corner of the bathroom and per RP according to Resident #142, they were there for two days. According to the Census information in the electronic medical records, the resident was in the following rooms during resident's stay in the facility: [redacted] Wing [redacted] Floor [redacted] Semi-Private [redacted] Wing [redacted] Floor [redacted] Semi-Private [redacted] Wing [redacted] Floor [redacted] Semi-Private A review of the provided folder of Pest Control Log (PCL) by the Licensed Nursing Home Administrator (LNHA) included invoice#430427 for a work date of 9/15/23; service description: pest-weekly service; general comments/instructions: Inspected areas on the first floor; treated rooms included room [redacted] as a continued preventative all baseboard heater vents	F 584	laundry staff were educated on proper handling of soiled items vs clean items. Housekeepers were immediately re-educated on high dusting and cleaning other elements in the resident rooms and dining room. Element Four - Quality Assurance: The following areas will be audited by the Housekeeping Director/Designee every week for cleanliness for one month and then twice monthly for two months. Results will be reported monthly to the QAPI team for review and revised as necessary, utilizing the Guardian Angel Rounds Sheet. The following areas will be audited by the Housekeeping Director/Designee as stated above: ¿ High dust areas in eight random rooms (4 on each unit) ¿ Dining room area ¿ Fans ¿ Air conditioners ¿ Suction Machine covering The Housekeeping Director/Designee will conduct an audit on five rooms weekly for broken toilet paper holders for one month and then twice monthly for two months. If broken toilet paper holders are located, the Housekeeping Director reports the finding to the Maintenance Director for replacement. The Housekeeping Director/Desginee will conduct an audit in the laundry area weekly times three for one month, and then monthly times two for two months. Results will be reported monthly to the QAPI team for review and revision.	

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F 584	Continued From page 7 in hallways were treated for roach activity. Recommend continued sanitation practices in the facility. On 9/19/23 at 10:46 AM, the surveyor and the Director of Nursing (DON) toured the [redacted] wing unit and entered room [redacted], there were no residents in the room at that time and the DON stated that the residents were in the activity. Upon entry, both the surveyor and the DON observed the blackish substances in the flooring edges around the door, bed [redacted] (a bed near the door) and bed [redacted] (a bed near the window) cork boards and overhead lights checked by the DON with use of her bare hands and observed an accumulation of dust. The DON stated that it should have been cleaned. Then both the surveyor and the DON went inside the shared toilet room and observed that the tissue holder was broken and no tissue paper. The DON further stated that she would have it fixed. According to the above information, this was the previous room of Resident #142. On 9/19/23 at 10:51 AM, the surveyor and the DON went to room two (2) and the two current residents were not in the room. Both the surveyor and the DON observed there was high dusting in both beds in their cork boards where the activity calendars were posted and the overbed lights. The DON confirmed the high dusting by DON touching the surfaces with her hands and noted dust accumulation. Room [redacted] was the previous room of Resident#142. The DON stated that it should have been cleaned. On 9/19/23 at 10:53 AM, the surveyor and the DON went to room [redacted] and both observed that	F 584		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 584	Continued From page 8	F 584		

the room was closed. The DON informed the surveyor that there were no residents in room [redacted] which was why it was closed, then the surveyor and the DON entered room [redacted] and there were two made beds (bed [redacted] and bed [redacted]), and there was an extra bed with no mattress. The surveyor asked the DON if that was appropriate to store an extra bed inside a clean room. The DON stated that it was "okay" to store an extra bed inside the room and that it would be removed once admission came in.

On that same date and time, both the surveyor and the DON observed the adjoined toilet room between rooms [redacted] and [redacted]. There was a broken bedpan with a minimal amount of water that was on the floor with no identification to whom the used bedpan was. The DON picked up the bedpan from the floor and the DON stated that it should not be there. There was also a urinal hung on the handrail, the used urinal had a yellow colored substance on the bottom part of the urinal and the DON stated that she did not know who was using the urinal and that it should not be there. The toilet holder was broken, the DON attempted to put the toilet paper but it would not hold.

2. On 9/19/23 at 10:38 AM, the surveyor toured the dining area. There were 16 residents and five (5) facility staff assisting the residents with activity. The surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN). The MDSC/RN informed the surveyor that the area was called the Recreation and Dining Area. Both the surveyor and the MDSC/RN observed the back wall of the dining area with scattered multiple black and brownish substances from the lower part to the top of the ceiling wall. There was

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 584	Continued From page 9	F 584		

a wall painting of a tree and a piano near the back of the wall. Next to the piano area were two vending machines (one machine for food/snacks and the other vending machine for drinks soda/water) at the back and bottom part were scattered papers, an empty carton of Ensure milk with a straw inside, round shape reddish candy, a coin, socket screwdriver, scattered accumulation of dust. Next to the two vending machines was the suction machine covered with plastic. The plastic covering of the suction machine had scattered holes and with accumulation of dust. The center area above the ceiling of the dining area was three (3) exhaust fans with dust accumulation. The three exhaust fans were in used.

At that same time, the MDSC/RN confirmed the above findings and stated that it should have been cleaned.

On 9/19/23 at 10:43 AM, the surveyor and the DON observed the Soiled Utility room in the [redacted] wing, the entrance flooring with blackish substances around the area edges and the DON confirmed that it should have been cleaned.

On 9/21/23 at 8:47 AM, the LNHA stated that he was aware of the surveyor's concerns regarding facility cleanliness and environmental issues.

Further review of the PCL, included invoice#426634 for a work date of 8/02/23; service description: pest-weekly service; general comments/instructions: Followed up on rooms completed in [redacted] wing rooms [redacted] for roach activity. Recommend cleaning each room thoroughly. Treated day room behind the piano for roaches. Treated bathrooms on the [redacted] and

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F 584	Continued From page 10 [redacted] side. 3. On 9/22/23 at 8:21 AM, the surveyor toured the Laundry area and observed Housekeeper#1 (HK#1), HK#2, HK#3, and Laundry Staff (LS). HK#1 stated that she will call the Housekeeping Director (HD) to assist the surveyor with the Laundry tour. HK#1 further stated that since the breakfast trays were in the units, housekeepers were in the laundry area to help in folding. Upon entry to the Laundry area there was a metal rack of donated clothes not covered, a table with folded blankets, a box of gloves, a plastic bottle of soda with below half liquid content, paper, and rolled plastic bags, across the table was another table with multiple socks on top which HK#3 putting them together and above the table where multiple socks was a hanging electric fan in use with surrounded accumulation of dust in the metal parts of the fan. There were 3 dryers not in use at that time. On 9/22/23 at 8:24 AM, the HD entered the laundry area and informed the surveyor in the presence of three housekeepers and LS that she started working in the facility for four weeks. The surveyor and the HD both observed the hanging electric fan in use with accumulation of dust and below was a folding table with multiple different clean socks. The surveyor asked the HD about the electric fan in use what was around the metal parts of the fan and how long she thinks it was not cleaned, the HD stated that it was dust and "probably," a week it was not clean. The HD further stated that she would ask the Porter who was responsible for cleaning the fan to clean it. The HD stated that those socks were considered clean and being folded and that the donation	F 584		

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F 584	Continued From page 11	F 584		

clothes in the metal racks were considered clean as well.

On that same date and time, the surveyor and the HD then went to the three metal racks near the table of folded blankets wherein on top of the metal rack was a plastic food container, a personal phone next to clean folded towels, in the middle of two metal racks was a feather duster touching the clean folded blankets. On the last metal rack on top were two plastic divider curtain which were dirty accumulation of dust and black and brown substances that was tucked between clean folded privacy curtain. The HD stated that the personal phone should not be placed in the clean folded towels, the feather duster used for cleaning should not be near the clean folded blankets and any other clean supplies, and the plastic divider curtain which will be replaced soon awaiting for replacement should not be tucked in a clean privacy curtain for residents due to contamination and infection control.

At the same time, the surveyor also asked the HD to check the metal racks for cleanliness and the HD swiped her fingers on top of the metal rack for cleaned folded blankets and fitted sheets and informed the surveyor that there was high dusting that should have been cleaned. The HD also stated that she would ask the LS to rewashed the contaminated supplies and she educated the housekeepers and the LS regarding personal phones and personal soda not being placed on the tables used for folding clean linens, towels, socks, blankets, and fitted sheets as well as cleaning equipment and supplies away from cleaned supplies.

Furthermore, the HD explained to the surveyor

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 09/28/2023

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

(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 584	Continued From page 12 that the [redacted] room was considered a clean area where the three dryers were located, and the next room in between the plastic divider curtain was considered the dirty room where the two washers were located. The HD confirmed that the plastic curtain divider had multiple scattered black and brown substances and accumulation of dust should have been cleaned. On 9/22/23 at 8:42 AM, the surveyor observed the shared toilet room of rooms [redacted] and [redacted], and the toilet paper dispenser was not fixed, the metal part was apart. On 9/22/23 at 8:47 AM, the surveyor observed the shared toilet room of rooms [redacted], the toilet paper dispenser was not fixed and missing a middle part that would hold the tissue paper. At that time, tissue paper was placed on top of the handrail of the toilet seat. On 9/22/23 at 8:49 AM, the surveyor, DON, and the Maintenance Director both went to the shared toilet of rooms [redacted], there were no residents in the rooms at that time. Both the surveyor and the facility management observed that there was a missing part on the toilet dispenser. The surveyor also notified the facility management that it was the same in the shared toilet room of rooms [redacted] and the Maintenance Director stated that he would be back to get the missing part replacement and will fix the one in rooms [redacted]. On 9/22/23 at 10:07 AM, the survey team met with the LNHA and the DON and were made aware of the above findings. On 9/25/23 at 10:35 AM, the survey team met	F 584		

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 09/28/2023

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

(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 584	Continued From page 13 with the LNHA and the DON. The LNHA informed the surveyor that rooms in the [redacted] wing (rooms *Ex Order 26. 4B1*) were immediately cleaned after the surveyor's inquiry. The LNHA acknowledged the high dusting and stated that the tissue holders were replaced immediately. He further stated that he acknowledged the concerns about environmental issues that were brought out by the surveyor during the environmental tour in the dining area, resident rooms, and laundry area. A review of the undated Housekeeping Policy that was provided by the LNHA included that it is the policy of this facility to provide and maintain a safe, clean, and homelike environment for residents. All equipment and environmental surfaces shall be clean to sight and touch. All toilets and bathrooms shall be kept clean to sight and touch, in good repair, and free of odors. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services. The facility management did not provide additional information and did not refute findings.	F 584		
F 585 SS=E	NJAC 8:39-31.2 (e), 31.4(a)(f) Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	F 585		10/12/23

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 09/28/2023

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

(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 585	Continued From page 14	F 585		

furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is

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 09/28/2023

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

(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 585	Continued From page 15 responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'	F 585		

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 09/28/2023

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 585	Continued From page 16 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Complaints: #NJ00164042, # NJ00166566, #NJ00165848, #NJ00166567 Based on observation, interview, and review of pertinent documents, the facility failed to ensure that the method for filing a grievance was consistent with the facility's practice and policy. This deficient practice was identified for five (5) of five (5) residents, (Residents #10, #13, #56, #82, and #143) reviewed. This deficient practice was evidenced by the following: 1. On 8/19/23 at 11:00 AM, the surveyor asked the Licensed Nursing home administrator (LNHA) for a copy of Resident #10's grievance reports for the last five (5) months, and the LNHA stated that he will get back to the surveyor. The provided Grievance/Complaint Report (G/CR) logs showed that the months of April 2023, May 2023, and August 2023 did not reflect a grievance logged for Resident #10. A review of Complaint #NJ00164042 reflected an alleged event date on 4/28/23 showed that the resident complained about a staff member yelled and attempted to give the resident with a wrong medication. A review of Complaint #NJ00166566 reflected an alleged event on 8/15/23 showed that Resident	F 585	Element One - Corrective Action: It is the practice of the Center to ensure that all grievances are entered on the grievance log. All complaints were immediately entered into the grievance log. The Social Service Director was educated to include all complaints in the grievance log, regardless of reporting entities. Element Two - Identification of at-Risk Residents: Residents #1, #13, #56, #82, and #143 did not meet this standard. All residents who file a complaint have the ability to be affected. Element Three - Systemic Change: The Social Service Director was educated to include all complaints in the grievance log, regardless of reporting entities. Element Four - Quality Assurance: The Social Worker/Designee will conduct a weekly audit to ensure resident concerns are entered into the grievance log for one month and then monthly for two months. Results will be reported monthly to the QAPI team for review and revision.	

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 09/28/2023

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

(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 585	Continued From page 17	F 585		

#10 reported Resident #13 inappropriately [redacted] Resident #82.

Further review of the above G/CR logs and complaint and reported concern of Resident #10 revealed that there was no grievance documentation that was initiated on 4/28/23 and 8/15/23.

The surveyor reviewed the medical records of Resident #10.

The resident's Admission Record (AR; or face sheet; admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to; [redacted].

The comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with assessment reference date (ARD) of 7/18/23 showed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15, which indicated that the resident's cognitive status was [redacted].

The surveyor reviewed the medical records of Resident #13.

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; [redacted]

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 09/28/2023

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

(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 585	Continued From page 18	F 585		

Ex Order 26. 4B1 [redacted].

The cMDS with an ARD of 8/03/23 showed that the resident's BIMS score was [redacted] out of 15, which indicated that the resident's cognitive status was *Ex Order 26. 4B1* .

The surveyor reviewed the medical records of Resident #82.

The resident's AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; *Ex Order 26. 4B1* [redacted].

The quarterly MDS (qMDS) with an ARD of 9/10/23 showed that the resident's BIMS score was [redacted] out of 15 which reflected that the resident's cognition was *Ex Order 26. 4B1* .

On 9/21/23 at 11:31 AM, the survey team met with the LNHA and the Director of Nursing (DON). The surveyor asked the facility management about the process of handling grievances. The DON stated that the staff would initiate the

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 09/28/2023

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

(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 585	Continued From page 19	F 585		

resident complaint form and it would be given to the Unit Manager, the DON or the LNHA.

On that same date and time, the LNHA stated that once the grievance was reported to New Jersey Department of Health (NJDOH), it will be followed up, and investigated. The LNHA further stated that he should be aware, and the grievance would be logged and filed for document keeping in the grievance binder. The LNHA informed the surveyors that he manages the grievance binder.

2. On 9/20/23 at 02:45 PM, the surveyor reviewed the reportable event record/report AAS-45 (FRE; Facility Reported Event) dated 7/10/23 that was provided by the facility which included the following:
Today's Date: 7/10/2023
Date of Event: 7/06/2023
Time of Event: unk [unknown]
Was This a Significant Event? Yes
Was Significant Event Called in? Yes Date: 7/10/2023 Time: 5:15 PM
Type of Incident: [redacted]
Narrative:
1) Describe the event ...
Resident #56 allegedly told Responsible Party (RP) that while [redacted] his/her [redacted] the individual described as [redacted] resident's [redacted]. He/she said that since the alleged incident, he/she has not seeing [seen] the person again ...
3) What interventions were implemented after the incident/event?...
[redacted] reveals with no [redacted] or [redacted] noted and Resident #56 was assessed and [redacted].
Resident #56 alleged incident happened in the

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 09/28/2023

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

(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 585	Continued From page 20	F 585		

evening to RP but upon his/her interviewed told the nurse it happened in the day shift and stated the person did not [redacted] him/her but was [redacted]. ..After reviewing all statements and visual assessment, no [redacted] or [redacted] noted on the patient's body, in addition to his/her discrepancies of the time of the incident and coupled with the description of the alleged perpetrators, we conclude that the allegation of [redacted] is unsubstantiated ....

Review of the additional documentation attached to the report included the following:
Copy of an email from Assistant Director of Nursing (ADON) to the former LNHA and the former Social Worker dated Fri. (Friday) Jul (July) 7, 2023 at 3:58 PM ...Resident #56's RP will be in on Monday 7/10/2023 to discuss concerns with her/his [parent].

The surveyor reviewed the medical record for Resident #56.

The AR reflected that the resident had been admitted with diagnoses which included but were not limited to [redacted].

The significant change in status MDS dated 6/30/23, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated that the resident's cognitive status was [redacted].

On 9/21/23 at 9:41 AM, the surveyor, in the presence of the LNHA asked the DON about Resident #56's FRE. The DON stated that she was not here at the time and that she was on

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 09/28/2023

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

(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 585	Continued From page 21	F 585		

vacation. She then asked the ADON to come to the office.

On 9/21/23 at 9:42 AM, the surveyor interviewed the ADON in the presence of the DON regarding Resident #56's FRE. The ADON stated that Resident #56's RP was told about the alleged incident by another RP the next morning. ADON stated that the alleged event happened on 7/06/23. The surveyor asked the ADON why the allegation of [redacted] was not reported right away and was reported on 7/10/23. The ADON stated that she did not that information.

On 9/21/23 at 11:31 AM, in the presence of the survey team, the surveyor asked the LNHA and DON what the process was for an allegation of [redacted]. The LNHA stated that the alleged threat is removed from the situation and that it is called in to the state and Ombudsman and then investigated [the allegation]. The surveyor then asked if there was a form that was used. The DON stated that it depended on the type of allegation but that they might fill out the AAS-45. She added that if someone alleged that they were [redacted] by a staff member then that person would be taken off the schedule, we would talk to the resident and to staff and that the resident would have a body assessment done. The surveyor then asked if there should be documentation in the medical record and where it would be located if a family member made an allegation of [redacted]. The LNHA stated that it would be documented in the grievance [log]. The DON stated that if would not be in the progress notes.

On 9/21/23 at 12:46 PM, in the presence of the survey team and DON, the surveyor asked the LNHA if the grievance form was used for

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 09/28/2023

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

(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 585	Continued From page 22	F 585		

everyone. The LNHA stated "yes." He then added that the monthly log was just to track but that each incident would have a form that was filled out. The surveyor then asked why was it important to maintain a record of complaints. The LNHA stated that it was to track and see if there were any trends.

A review of Resident #56's Progress Notes from 7/01/23 to 7/13/23 did not include a note that a RP alleged [redacted] by a staff member.

A review of the facility provided Grievance Log for July 2023 did not include an allegation of [redacted] in regards to Resident #56.

On 9/22/23 at 10:38 AM, in the presence of the survey team, the surveyor notified the LNHA and DON the concern that Resident #56's allegation of [redacted] by the resident's RP was not listed as a grievance in the facility's grievance log. The LNHA stated that it seemed that the facility did not put allegations of [redacted] on the grievance form if it was reported to the state.

On 9/27/23 at 01:38 PM, in the presence of the survey team and the DON the LNHA stated that there was no additional information but that moving forward the facility would put reportable's on the grievance form/log.

3. On 9/19/2023 at 1:07 PM, in the presence of the survey team, the surveyor asked the LNHA to confirm that the requested reportable to the State Agency (SA) was submitted to the team its entirety.

At that time, LNHA stated he would have to confirm with nursing.

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 09/28/2023

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

(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 585	Continued From page 23 The LNHA stated that the investigation and reportable were in one sheet and section three (3) was the conclusion. Once a reportable event occurred, we (the LNHA, nursing and social worker) investigated, and interviewed all parties. The LNHA stated that the SA form AAS-45 was used to document the information gathered from the investigation, interviews, and conclusion. The witnesses, when applicable would write their statement on a piece of paper. The surveyor reviewed the Reportable Event Record/Report form AAS-45 (a facility reported event/incident; FRE/FRI) for Resident #143 which included the following: Today's Date: 8/14/23 Date of Event 8/12/23 Time of Event 11:30 PM Was this a significant event? No Was significant event called in? Yes, 8/14/23 at 2:20 PM Location of Incident: Facility enclosed patio Type of Incident: Staff to Resident [redacted] 1) On 8/14/23, Resident #143 reported that on 8/12/23 at approximately 11:30 PM, [he/she] was talked to rudely by staff. 2) Prior to the event, was a plan of care developed that addressed this issue, and were planned interventions in place when the event occurred? Not Applicable 3) What interventions were implemented after the incident/event?... The employee was removed off the schedule. the physician and psych were notified of the event. administration reviewed the policy with Resident#143 about going outdoors after hours. during our investigation, it was noted that Resident #143 was observed sitting on the ground on the enclosed patio with legs crossed	F 585		

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 09/28/2023

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

(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 585	Continued From page 24	F 585		

looking for used cigarette butts. the staff asked [the resident] to stop and return indoors because it was late. [The resident] began to yell and curse at him/her. After a short while, he/she was eventually able to coax [the resident] to their room, despite objections.

Ex Order 26. 4B1 in this case was found to be unsubstantiated ...

The surveyor reviewed the facility provided Grievance log for August 2023, which did not include the FRE for Resident #143.

The surveyor reviewed the medical records for Resident #143.

A review of the resident's AR reflected that Resident #143 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]

According to the admission MDS dated 8/16/23, Resident #143 was documented with a BIMS score of [redacted] out of 15, indicated that resident was Ex Order 26. 4B1 .

Further review of the MDS section E Behavior revealed the resident was Ex.Order 26.4(b)(1) and section N revealed the resident received Ex Order 26. 4B1 , and Ex Order 26. 4B1 medications.

On 9/21/23 at 11:31 AM, during a meeting with the surveyors, and the DON the LNHA stated he

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 09/28/2023

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 585	Continued From page 25 was the Ex Order 26. 4B coordinator since 7/31/23, when he started with the facility. The LNHA explained the process for allegation of Ex Order 26. 4B. At that time, the LNHA stated that allegations were documented into the grievance log or risk management report. The LNHA further clarified that grievance forms, complaints, and missing items were documented into the grievance log. The Social Worker (SW) kept the grievance forms and the grievance log. The grievance log was checked by the LNHA every morning and discussed during the morning and afternoon meeting to bring awareness to everyone. At that time, the DON stated the Social Worker would conduct interviews and write a statement that is not on the electronic file. After the whole investigation the SA and the Ombudsman are notified. After the conclusion whether substantiated or not we do not assign the same Certified Nursing Assistant CNA/or staff to the same resident to prevent further issues. At that time, the LNHA stated for reported events/incident (FRE/FRI), the SA form AAS-45 is utilized. He further stated that the unreported events and if we obtain a statement, it would be on the grievance form which the SW kept. The LNHA informed the surveyor that "She is the end person of the reporting process." The LNHA further stated that all staff can initiate the reporting process. On 9/21/23 at 12:46 PM, during a follow up interview with the surveyors, the LNHA and the DON stated the resident concern form was used to track all concerns with residents, family and other types. The record was important to track for	F 585		

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 26	F 585		

trend issues and concerns. The trends were tracked by the department heads who also reported during our morning and afternoon meetings.

At that time, the surveyor asked the LNHA how grievances were identified and tracked for trend since Resident #143's grievance was not documented on the grievance log. The LNHA stated we do not have a way to track the trend of grievances.

On 9/22/23 at 10:09 AM, during a meeting with the survey team, LNHA and DON, the surveyor discussed the concerns regarding the facilities process failure of receiving and tracking the trend for grievances.

On 9/25/23 at 10:56 AM, during a meeting with the survey team, and the DON, the LNHA stated after the surveyor inquiry, they added Resident #143' a information to the grievance log. The LNHA stated their process was that when a concern was brought to the attention of a facility representative, we then would log the information into the grievance log.

At that time, the LNHA acknowledged the Resident #143's grievance regarding a staff to resident [redacted] should have been record into the grievance log for trend tracking.

No further information was provided.

A review of the facility provided policy Resident Grievance/Complaint Policy included:
Policy Statement; Any resident his/her representatives (sponsor), interested family member or advocate may file a

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 09/28/2023

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 585	Continued From page 27	F 585		

grievance/complaint concerning his/her treatment, medical care, behavior of other residents, staff members, theft of property, etc., without fear of reprisal in any forms.
Procedure:
1. Obtain a complaint form from the nurse's station or social services office.

A review of the facility provided policy titled, "Prohibition of Resident Abuse & Neglect" dated 3/18/23, included the following:
Prevention
3. Encourage residents, families and staff to report concerns, incidents and grievances without the fear of retribution and provide feedback regarding the concerns that have been expressed.
Reporting
1. Any witnessed, alleged, or suspected violations involving mistreatment, neglect or abuse, ...MUST BE REPORTED IMMEDIATELY TO THE EMPLOYEE'S SUPERVISOR.
2. The supervisor must immediately notify the Administrator and/or the Director of Nursing.
3. Abuse allegations ...will be REPORTED IMMEDIATELY to the appropriate authorities by the Administrator and/or the Director of Nursing including but not limited to local law enforcement agencies, NJDOH, and NJ Ombudsman in compliance with regulatory requirements.
4. Reports must be submitted in writing, which may include incident report, employee statement, grievance/concern form, or other written documentation ...
7. Upon receiving reports of abuse ...the Charge Nurse and/or Nursing Supervisor shall immediately examine and interview the resident.
8. The information and examination will be recorded in the resident's medical record ...

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 09/28/2023

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 585	Continued From page 28 18. Appropriate agencies will be contacted by telephone to report instances of abuse immediately, including but not limited to NJDOH, the local police, and the Office of the Ombudsman. 19. A written report will follow as required by the reporting agency. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services. The facility management did not provide additional information and did not refute findings.	F 585		
F 607 SS=D	NJAC 8:39-4.1(a)(35);13.2(c) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607		10/12/23

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 09/28/2023

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 607	Continued From page 29 but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility it was determined that the facility failed to implement the facility's Ex. Order 26. 4(b) policy to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for six (6) of ten (10) newly hired staff reviewed, (Staff #1, #2, #6, #7 #8, and #9). This deficient practice was evidenced by the following: On 9/28/23 at 8:30 AM, the surveyor reviewed nine randomly selected new employee files for license verification which revealed the following: Staff #1, a Certified Nursing Assistant (CNA), hired 10/24/21, had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which did not include the date that the verification was done. Staff #2, a Physical Therapy Assistant (PTA), hired 12/20/21, had a New Jersey Division Consumer Affairs license verification printout (used to verify the status of a licensed	F 607	Element One - Corrective Action: It is the practice of the Center to ensure that all employees have credentials verified before hire. This standard was not met for Staff #1, #2, #6, #7, #8, and #9. Staff #1, #2, #6, #7, and #8 all had credential verification on file after their hire date. Verification for staff #9 was completed immediately. The Facility hired a new qualified Human Resources Director on Ex.Order 26.4(b)(1). The Human Resources Director was educated to verify employees' credentials before the hire date. An audit was completed on all current employee files to ensure credentials have been verified. Element Two - Identification of at-Risk Residents: All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: An Employee File Checklist was created for the Human Resources Director to utilize upon hire, and the Administrator/designee was to review two files before the hire date for three months	

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 09/28/2023

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 607	Continued From page 30 professional other than a CNA) which had accurate as of December 22, 2021 2:48 PM. The date was two days after the date of hire. Staff #6, a Licensed Practical Nurse (LPN), hired 7/12/21, had a New Jersey Division Consumer Affairs license verification printout which had accurate as of November 18, 2021 4:55 PM. The date was four months after the date of hire. Staff #7, a Registered Nurse (RN), hired 01/26/23, had a New Jersey Division Consumer Affairs license verification printout which had accurate as of September 26, 2023 11:35 AM. The date was eight months after the date of hire. Staff #8, a Certified Nursing Assistant (CNA), hired 7/26/22, had a NJDOH online Public Registry license verification printout that was dated 9/24/23 12:32 PM. The date was more than 1 year after the date of hire. Staff #9, a Certified Nursing Assistant (CNA), hired 3/26/23, did not have a NJDOH online Public Registry license verification printout. There was no documented evidence that Staff #9's license was verified. On 9/28/23 at 9:44 AM, the surveyor interviewed the Human Resource Director (HRD) regarding the process for license verification of newly hired employees. The HRD stated that after the employee was interviewed, she would do the license verification. The surveyor asked when the date of hire was. The HRD stated that the hire date was once they clear everything. She added all should be done prior to the hire date and that date was when the employee started on the floor even if they were only shadowing another	F 607	and then to be re-evaluated depending on findings. This audit will serve as a second verification of all needed credentials for new staff members. All licenses were inputted into an electronic workforce management system which enables the facility to run monthly reports to track and ensure all licensed employees comply with their credentials. Element Four - Quality Assurance: Results will be reported monthly to the QAPI team for review and revision.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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 607	Continued From page 31 employee. On that same date and time, the surveyor asked when the HRD started at the facility. The HRD stated that she had started on 8/21/23. The surveyor asked the HRD if the employee files that were provided to the surveyor were the complete files. The HRD stated that she could not speak for someone else's work and that if the prior person went through her process that the files should be complete. On 9/28/23 at 10:27 AM, in presence of another surveyor, the HRD confirmed that six of the nine employees did not have the license verification prior to date of hire. On 9/28/23 at 11:47 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that the employees did not have a license verification prior to date of hire. On 9/28/23 at 11:58 AM, in the presence of the survey team and LNHA, the DON stated that the employees should have license verification before date of hire. A review of the undated facility provided policy, titled "New Hire and Onboarding Process" included the following: Prior to a start date: Valid ....NJ State License (RN, LPN, C.N.A., etc.) A review of the facility provided policy titled, "Prohibition of Resident Abuse & Neglect" dated 3/18/23, included the following: Employee and Volunteer Screening	F 607		

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 09/28/2023

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 607	Continued From page 32 2. Inquiry of State Nurse Aide Registry for CNA applicants 3. Inquiry of licensing authorities for all licensed/certified positions... N.J.A.C. 8:39-43.15(a)	F 607		
F 609 SS=E	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 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	F 609		10/12/23

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 09/28/2023

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F 609	Continued From page 33 by: Complaints: #NJ00164042, # NJ00166566, NJ#165848 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of *Ex Order 26. 4B1* in accordance with federal and state requirements for the timing of reporting such allegations of *Ex Order 26. 4B* to the state agency. The deficient practice was identified for four (4) of six (6) investigations of reportable incidents reviewed (Residents #10, #13, #56 and #82). This deficient practice was evidenced by the following: 1. On 8/19/23 at 11:00 AM, the surveyor asked the Licensed Nursing home administrator (LNHA) for a copy of Resident #10, #13 and #82 Incident/Accident and Reportable (I/A&R) reports for the last five (5) months, and the LNHA stated that he will get back to the surveyor. A review of the provided I/A&R reflected that Complaint #NJ00164042 and # NJ00166566 were both reported beyond the required timeframe as follows: The Staff to Resident allegation of abuse of Resident #10 with a Complaint # NJ00164042 reflected an alleged event date on 4/28/23 at 5:35 PM and intake receive date of 5/05/23 at 3:30 PM. The Resident to resident allegation of *Ex Order 26. 4B* of Resident #10 that included Resident #13 and #82, with a Complaint # NJ00166566 reflected an	F 609	Element One - Corrective Action: It is the practice of the Center to ensure that all reportable events for allegations of *Ex Order 26. 4B* are reported to the Department of Health within 2 hours. All allegations of *Ex Order 26. 4B* will be reported to the Department of Health within 2 hours. Element Two - Identification of at-Risk Residents: Residents #10, #13, #56 and #82 did not meet this standard. All residents identified in this deficient practice continue to reside at the facility. This deficient practice can potentially affect all residents with allegations of *Ex Order 26. 4B*. An audit was completed by the Administrator and DON of the last 30 days of incidents to ensure that all incidents regarding *Ex Order 26. 4B* were investigated and reported to the NJDOH and the Ombudsman's office. Element Three - Systemic Change: Staff re-in-serviced on *Ex Order 26. 4B*, including recognizing and reporting abuse. Staff in-serviced on proper placement of residents post-incident. Staff educated all allegations of *Ex Order 26. 4B* regarding a staff member-the staff member must be suspended pending further investigation. Education was also completed with the Licensed Nursing Home Administrator and the Director of Nursing on *Ex Order 26. 4B*, including facility policy reporting *Ex Order 26. 4B* to the appropriate agencies promptly. Element Four - Quality Assurance: To maintain and monitor ongoing	

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 09/28/2023

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

(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 609	Continued From page 34 alleged event date on 8/15/23 at approximately 8:00 AM and intake receive date of 8/17/23 at 01:33 PM. The surveyor reviewed the medical records of Resident #10. The resident's Admission Record (AR; or face sheet; admission summary) reflected that Resident #10 was admitted to the facility with diagnoses that included but not limited to; *Ex Order 26. 4B1* [redacted]. The comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) 7/18/23 showed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15 which indicated that resident's cognitive status was [redacted]. The surveyor reviewed the medical records of Resident #13. Resident #13's AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; *Ex Order 26. 4B1* [redacted]	F 609	compliance, LNHA/designee will audit completed investigations daily x 14 days, twice weekly x4 weeks, and then monthly x2. Needed corrections will be addressed as they are discovered. Findings will be reported monthly to the QAPI team for review and action as necessary. In addition, the DON/designee will monitor all incidents /accidents and 24-hour reports, including progress notes, daily times five at clinical morning meetings for any indication of abuse and investigate and report accordingly.	

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 09/28/2023

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 609	Continued From page 35	F 609		

Ex Order 26. 4B1 [redacted].

The cMDS with an ARD of 8/03/23 showed that the resident's BIMS score was [redacted] which indicated that resident's cognitive status was *Ex Order 26. 4B1* [redacted].

The surveyor reviewed the medical records of Resident #82.

Resident #82's AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to; *Ex Order 26. 4B1* [redacted].

The quarterly MDS (qMDS) with an ARD of 9/10/23 showed that the resident's BIMS score was [redacted] which indicated that the resident's cognitive status was *Ex Order 26. 4B1* [redacted].

2. On 9/20/23 at 02:45 PM, the surveyor reviewed the reportable event record/report AAS-45 (FRE; Facility Reported Event) dated 7/10/23 that was provided by the facility which included the following:
Today's Date: 7/10/2023
Date of Event: 7/06/2023

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 09/28/2023

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 609	Continued From page 36 Time of Event: unk [unknown] Was This a Significant Event? Yes Was Significant Event Called in? Yes; Date: 7/10/2023; Time: 5:15 PM; Type of Incident: *Ex Order 26. 4B1* [redacted] Review of the additional documentation attached to the report included the following: Body Check V 3.1 Effective date: 7/07/2023 01:41 PM. Other, specify: Ex.Order 26.4(b)(1) [redacted]. Signed date: 7/07/2023. Copy of an email from Assistant Director of Nursing (ADON) to the former LNHA and the former Social Worker dated Fri. (Friday) Jul (July) 7, 2023 at 3:58 PM ...Resident #56's Responsible Party#1 (RP#1) will be in on Monday 7/10/2023 to discuss concerns with her/his [parent]. The surveyor reviewed the medical record for Resident #56. The AR reflected that the resident had been admitted with diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted]. The significant change in status MDS dated 6/30/23, reflected that the resident had a BIMS score of [redacted] out of 15, which indicated the resident had *Ex Order 26. 4B1* [redacted]. On 9/21/23 at 9:41 AM, the surveyor, in the	F 609		

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 09/28/2023

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

(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 609	Continued From page 37	F 609		

presence of the LNHA asked the DON about Resident #56's FRE. The DON stated that she was not here at the time and that she was on vacation. She then asked the ADON to come to the office.

On 9/21/23 at 9:42 AM, the surveyor interviewed the ADON in the presence of the DON regarding Resident #56's FRE. The ADON stated that Resident #56's RP#1 was told about the alleged incident by RP#2 the next morning. ADON stated that the alleged event happened on 7/06/23. The surveyor asked the ADON why the allegation of abuse was not reported right away and was reported on 7/10/23. The ADON stated that she did not have the information.

On 9/21/23 at 11:31 AM, in the presence of the survey team, the surveyor asked the LNHA and DON what the process was for an allegation of abuse. The LNHA stated that the alleged threat is removed from the situation and that it is called in to the state and Ombudsman and then the allegation was investigated. The surveyor asked if there was a timeframe that the allegation of abuse was to be reported to the NJDOH. The LNHA stated that the timeframe was right away if it was abuse, within one hour.

At that same time, the surveyor then asked if there was a form that was used. The DON stated that it depended on the type of allegation but that they might fill out the AAS-45 (FRE form from NJDOH). She added that if someone alleged that they were hit by a staff member then that person would be taken off the schedule, we would talk to the resident and to staff and that the resident would have a body assessment done. The surveyor then asked if there should be

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 09/28/2023

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 609	Continued From page 38 documentation in the medical record and where it would be located if a family member made an allegation of [redacted]. The LNHA stated that it would be documented in the grievance [log]. The DON stated that it would not be in the progress notes. On 9/21/23 01:28 PM, the LNHA stated that he spoke with the former LNHA and that the former LNHA stated that he was notified on July 10, 2023 when he met with Resident #56's family and that was when the former LNHA reported the allegation to NJDOH. The LNHA stated that the ADON emailed the former LNHA and former Social Services Director on 7/07/23 that Resident #56's family would be in on 7/10/23 to discuss concerns regarding Resident #56. The surveyor then asked the LNHA if the facility was notified of the allegation of [redacted] on 7/10/23 then would not the Ex.Order 26.4(b)(1) be dated 7/10/23 and not 7/07/23. The LNHA stated "yes." On 9/21/23 at 3:38 PM, the surveyor reviewed the assessment tab in the electronic medical record of Resident #56 and there was only one [redacted] dated 7/07/23 from the time period of June 2022 to present. A review of the July 2023 Medication and Treatment Administration Record did not indicate there was a weekly order for a Ex.Order 26.4(b)(1) that could have been done on 7/07/23. On 9/22/23 at 7:37 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) that signed Resident #56's Ex.Order 26.4(b)(1) dated 7/07/23 regarding what situations would a [redacted] might be done. The LPN stated that if a resident had a fall and if a staff member saw something different on a resident then a [redacted]	F 609		

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 09/28/2023

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F 609	Continued From page 39	F 609		

assessment would be done. The surveyor asked if a Ex.Order 26.4(b)(1) would be done if someone complained about someone hitting them. The LPN stated "yes" and that usually he would document the reason why the Ex.Order 26.4(b)(1) was done in a note. The surveyor then asked the LPN about the reason Resident #56's Ex.Order 26 [redacted] was done on 7/07/23. The LPN did not recall why the Ex.Order 26.4(b)(1) was done that day.

A review of Resident #56's Progress Notes from 7/01/23 to 7/13/23 did not include a note that indicated the reason why the Ex.Order 26.4(b)(1) was done on 7/07/23 and did not include a note that a family member alleged Ex.Order 26. 4B by a staff member.

On 9/22/23 at 9:20 AM, in the presence of the LNHA and DON, the surveyor asked the ADON what time the meeting was on 7/10/23 between Resident #56's daughter and the former LNHA. The ADON stated that the meeting was at 10 am.

On 9/22/23 at 10:38 AM, in the presence of the survey team, the surveyor notified the LNHA and DON the concern that Resident #56's allegation of Ex.Order 26. 4B [redacted] was not reported immediately or within two hours to the NJDOH.

On 9/27/23 at 01:38 PM, in the presence of the survey team and the DON, the LNHA stated that there was no additional information. The LNHA stated that from the emails the former LNHA met with the family on that Monday (7/10/23) and called it in on Monday (7/10/23). The surveyor asked if the meeting was at 10 AM then why was it not called in until 5:15 PM that evening. The LNHA did not provide any further information.

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 40 A review of the facility provided policy titled, "Prohibition of Resident Abuse & Neglect" dated 3/18/23, included the following: Prevention 3. Encourage residents, families and staff to report concerns, incidents and grievances without the fear of retribution and provide feedback regarding the concerns that have been expressed. Reporting 1. Any witnessed, alleged, or suspected violations involving mistreatment, neglect or abuse, ...MUST BE REPORTED IMMEDIATELY TO THE EMPLOYEE'S SUPERVISOR. 2. The supervisor must immediately notify the Administrator and/or the Director of Nursing. 3. Abuse allegations ...will be REPORTED IMMEDIATELY to the appropriate authorities by the Administrator and/or the Director of Nursing including but not limited to local law enforcement agencies, NJDOH, and NJ Ombudsman in compliance with regulatory requirements. 4. Reports must be submitted in writing, which may include incident report, employee statement, grievance/concern form, or other written documentation ... 7. Upon receiving reports of abuse ...the Charge Nurse and/or Nursing Supervisor shall immediately examine and interview the resident. 8. The information and examination will be recorded in the resident's medical record ... 18. Appropriate agencies will be contacted by telephone to report instances of abuse immediately, including but not limited to NJDOH, the local police, and the Office of the Ombudsman. 19. A written report will follow as required by the reporting agency.	F 609		

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 41 On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings.	F 609		
F 657 SS=D	N.J.A.C. 8:39-5.1(a), 13.4(c)(2)(v) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		10/12/23

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on interviews, and review of the facility provided documents, it was determined that the facility failed to revise a care plan to address the discharge plan for one (1) of three (3) residents reviewed for closed record, (Resident #90) reviewed for a comprehensive person-centered care plan. This deficient practice was evidenced by the following: The surveyor reviewed Resident #90's medical records. The Admission Record (or face sheet; an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted]. The admission Minimum Data Set (aMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 7/26/23 showed Section C Cognitive Patterns a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognitive status was [redacted]. The aMDS Section Q Participation in	F 657	Element One - Corrective Action: It is the practice of the Center to ensure that all residents with the potential of discharge have a discharge care plan. The Social Worker/Designee will audit all residents with a planned or potential discharge to ensure a discharge care plan is in place. A change in discharge status will be updated on care plans and addressed with the team as they are discovered. The social worker was educated on timely updating of care plans when a resident has a change in discharge plans. The Interdisciplinary Care Planning Team was re-educated on the timely updating of care plans as needed for change in the discharge plan. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #9. Resident #9 has been discharged from the Center. This deficient practice can affect all residents with the potential of discharge. Element Three - Systemic Change: The Social Worker/Designee will audit all residents with a planned or potential discharge to ensure a discharge care plan is in place. A change in discharge status will be updated on care plans and addressed with the team as they are discovered. Element Four - Quality Assurance:	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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 657	Continued From page 43 Assessment and Goal Setting revealed that the resident participated in the assessment and the resident's overall goal established during the assessment process that the resident Ex.Order 26.4(b)(1) [redacted]. A review of the Progress Note (PN) dated 8/17/23 in the electronic medical record by Social Worker#1 (SW#1) revealed that the resident was *Ex Order 26. 4B1* and was Ex.Order 26.4(b)(1) [redacted]. In addition, the 8/17/23 PN included that the resident was a long-term care (LTC) resident and had plans to be discharged (d/c) to the community. Further review of the 8/24/23 PN included that the resident came to SW#1 and communicated that the resident would like to be d/c "next week." The SW also documented that SW to follow up and begin the d/c process. The baseline care plan dated 7/20/23 in the electronic medical record showed that the initial admission/discharge goals were blank. A review of the baseline care plan dated 8/16/23 revealed that the initial admission/discharge goal was to remain in the facility and that the discharge plans were not initiated. Further review of the electronic medical record showed that the comprehensive personalized care plan did not include revision of the d/c care plan when the resident communicated to the SW on 8/17/23 and 8/24/23 that the previous plan for being a LTC resident was changed to be d/c to the community. On 9/26/23 at 01:29 PM, the surveyor interviewed	F 657	An audit of two discharged residents will be completed once a week to ensure discharge care plans are in place and updated and revised as needed. Results are to be reported monthly to the QAPI team for review and revision as necessary.	

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 09/28/2023

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 657	Continued From page 44	F 657		

SW#2 who informed the surveyor that she replaced SW#1 and SW#2 started on September 21, 2023. SW#2 stated that discharge planning starts on admission and is documented in the baseline care plan within 48 to 72 hours upon admission and care plan revision as needed. She further stated that if there will be a change in the d/c plan, there should be an interdisciplinary (IDCP) meeting to make sure that the d/c plan is safe and care plan will be updated.

On 9/27/23 at 8:44 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of another surveyor. The surveyor notified the DON of the above findings. The surveyor then asked the DON why the resident's care plan was not revised on two opportunities that the resident communicated on 8/17/23 and 8/24/23 his/her plan to be d/c to the community. The DON did not respond.

On 9/27/23 at 01:22 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the DON and notified them of the above findings.

A review of the facility's Discharge Planning Policy that was provided by the DON with a revised date of 3/29/23 included that Goal: the resident's needs pertaining to post-discharge care will be assessed upon admission. The IDCP team members will perform the assessment. A plan to meet these needs will be developed and interventions to meet specific discharge planning goals will be designed. The plan will be monitored and revised as necessary throughout the nursing home stay. Process: at the time of admission the following tasks will be accomplished by the following disciplines indicated if necessary. 1.

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 45 Admissions will notify all departments of a resident's admission status, i.e. short -term or long-term. 2. IDCP team will meet within 72 hours after the admission of a short term resident to discuss placement status. Care plans will be written for each of the identified residents which shall include the problem, goals, and interventions. ...7. The discharge planning process will begin with the pre-admission screen review and the *Ex Order 26. 4B1* Planning Schedule which are communicated to the whole IDCP team. A review of the facility's undated Interdisciplinary Care Planning Policy and Procedures that was provided by the LNHA included that it is the policy of this facility to establish an individualized interdisciplinary plan of care for each resident within seven days of completion of the MDS assessment. In addition, the IDCP must evaluate resident progress a minimum of quarterly or as required by changes in the resident's condition. Procedure: An interim plan of care that addresses the immediate care needs of the resident will be initiated by nursing on the day of admission. An interdisciplinary note will be completed at the conclusion of the care conference that provides the rationale for care plan decisions and will be signed by all in attendance. The IDCP team will assess each resident at a minimum of once every three months to determine if any changes are needed to the care plan of care. Since the care plan is a dynamic document, in the interim between quarterly reviews, the IDC team must revise problems, goals, and interventions in response to changes in the needs of residents. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of	F 657		

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 09/28/2023

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F 657	Continued From page 46 Clinical Services for an Exit Conference and the facility did not refute findings. The facility management did not provide additional information.	F 657		
F 658 SS=D	NJAC 8:39-11.2 (e, 1) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility staff failed to follow a physician's order for one (1) of nineteen (19) residents reviewed (Resident #5). This 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 stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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."	F 658	Element One - Corrective Action: It is the practice of the Center to ensure that all physician orders are followed. Resident #5's chart was immediately corrected to include Ex.Order 26.4(b)(1) for all three shifts. An audit was conducted on all residents who ordered Ex.Order 26.4(b)(1) medications, and no other findings were noted. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #5. All residents that are on Ex Order 26. 4B1 drugs have the potential to be affected. Element Three - Systemic Change: The DON and Administrator met with the Unit Manager and nursing staff to review the requirements for all residents on Ex.Order 26.4(b)(1) drugs, including Ex.Order 26.4(b)(1) for all shifts.	10/12/23

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 47 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "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 9/20/23 at 11:20 AM, the surveyor observed Resident #5 seated in a wheelchair in the resident's room. The surveyor reviewed Resident #5's medical record. The Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; *Ex Order 26. 4B1* [redacted] The quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 8/10/23, indicated a Brief Interview for Mental Status (BIMS) score of	F 658	Element Four - Quality Assurance: The Unit Manager/Designee will audit all residents on Ex.Order 26.4(b)(1) for Ex.Order 26.4(b)(1) all three shifts weekly for three months to ensure that all residents on Ex.Order 26.4(b)(1) medications have their Ex.Order 26.4(b)(1). Results will be reported monthly to the QAPI team for review and revision.	

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 658	Continued From page 48 [redacted] out of 15, which reflected that the resident's cognition was [redacted]. Further review of the qMDS indicated the resident received *Ex Order 26. 4B1* medication *Ex Order 26. 4B1* [redacted]. A review of Resident #5's September 2023 Medication Administration Record (MAR) and Treatment Administration Record (TAR) included the following orders: 1. Ex.Order 26.4(b)(1) [redacted] See Key every shift for Ex.Order 26.4(b)(1) [redacted] (S) EXHIBITED: 0. NONE 1. Agitated 2. Anxious 3. Biting 4. Pacing 5. Crying 6. Screaming/Yelling 7. Hallucinations/Paranoia/Delusions 8. Insomnia 9. Striking out/hitting 10. Withdrawn-Order Date 11/04/2021 0021 Each shift for each day were signed by the nurse with a check mark which was not a symbol that was indicated in the key under the physician's order. The surveyor was unable to determine if the resident had any behaviors since the numbers that were indicated to use under the key were not used. 2. Ex.Order 26.4(b)(1) [redacted] See Key every shift Record Potential Side Effects: 0. None 1. Stiff Neck 2. Tremors 3. Confusion 4. Tardive Dyskinesia 5. Hypotension/Dizziness 6. Dehydration 7. Insomnia 8. Anxiety/ Agitation 9. Sedation 10. Appetite Changes-Order Date 11/04/2021 0021 Each shift for each day were signed by the nurse with a check mark which was not a symbol that was indicated in the key under the physician's	F 658		

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 09/28/2023

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 658	Continued From page 49	F 658		

order. The surveyor was unable to determine if the resident had any Ex.Order 26.4(b)(1) to the medication they received since the numbers that were indicated to use under the key were not used.

The surveyor then reviewed Resident #5's June 2023, July 2023 and August 2023 MAR/TAR which indicated that the two orders for Ex.Order 26.4(b)(1) had a check mark for each shift of each day and not a number that was indicated in the key under the order.

On 9/20/23 at 11:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding a physician's order for Ex.Order 26.4(b)(1). The LPN stated that in the MAR/TAR there would be an order for the Ex.Order 26.4(b)(1) and that there is a number for either Ex.Order 26.4(b)(1) or a Ex.Order 26.4(b)(1) like Ex.Order 26.4(b)(1). The surveyor asked the LPN if there would be a check mark that the nurse puts on the MAR/TAR. The LPN stated that it would have a number and not a check mark.

On 9/20/23 at 01:25 PM, the surveyor interviewed the Director of Nursing (DON) regarding a physician's order for Ex.Order 26.4(b)(1). The DON stated that there is an order in the MAR/TAR and that the order had numbers equivalent to a Ex.Order 26.4(b)(1) none to indicate there was Ex.Order 26.4(b)(1). The surveyor then asked the DON to view Resident #5's printed September 2023 MAR/TAR. The surveyor asked the DON if the check marks on the two orders were the correct way to document the Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1). The DON stated that she would get back to the surveyor and that it might be a glitch.

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 09/28/2023

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

(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 658	Continued From page 50 On 9/21/23 at 9:17 AM, the DON stated that there must have been a glitch in the computer system and that the system did not generate the number key for the two orders. The surveyor asked the DON who would view the MAR/TAR to do the monthly summary recap of Ex.Order 26.4(b)(1). The DON stated that the Unit Manager (UM) would do the summary but that she was on vacation. The surveyor asked the DON what the process was for doing the monthly recap of Ex.Order 26.4(b)(1). The DON stated that the UM would look at the resident's progress notes, talk to staff and look at the MAR/TAR. The surveyor asked the DON if the UM should have seen that the physician order was not followed prior to surveyor inquiry. The DON stated that the UM could have picked it up if she had looked at the MAR/TAR. The surveyor asked what the expectation was to see how many episodes a resident had Ex.Order 26.4(b)(1). The DON stated that the expectation would be to look at the monthly MAR/TAR to count how many episodes of Ex.Order 26.4(b)(1) the resident had. On 9/22/23 at 10:39 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator and the DON the concern that Resident #5's physician's order for Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1) was not followed as ordered. On 9/27/23 at 01:43 PM, in the presence of the survey team and LNHA, the DON stated that Resident #5's physician's order was fixed in the computer system and that the error should have been picked up earlier. A review of the facility provided policy titled "Physician Medication Orders" with a revised date of December 2020, did not include information	F 658		

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 09/28/2023

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F 658	Continued From page 51 regarding physician orders for Ex.Order 26.4(b)(1) [redacted] A review of the undated facility provided policy titled Ex.Order 26.4(b)(1) [redacted] " did not include information regarding following a physician's order for Ex.Order 26.4(b)(1) on the MAR/TAR. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings.	F 658		
F 661 SS=D	N.J.A.C. 8:39-11.2 (b) Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is	F 661		10/12/23

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 09/28/2023

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F 661	Continued From page 52 developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that: a) a physician order for Ex.Order 26.4(b)(1) was obtained for two (2) of two (2) residents (Resident #84 and #142) and b) Ex.Order 26.4(b)(1) was completed by the physician for one (1) of two (2) residents who were transferred to another facility (Resident #142) reviewed for Ex.Order 26 This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical records of Resident #84. The Admission Record (or AR; face sheet; an admission summary) reflected that the resident was admitted to the facility and had diagnoses that were not limited to *Ex Order 26. 4B1* [redacted]. A review of the admission Minimum Data Set (aMDS), an assessment tool used to facilitate the	F 661	Element One - Corrective Action: It is the practice of the Center to ensure that all discharged patients have a discharge order and a discharge summary. Discharge orders were not in place for Residents #84 and #142, and discharge summary was not completed for Resident #142. Residents #84 and #142 have been discharged from the facility. Discharge orders for residents #84 and #142 were obtained from Physician. Discharge summary for resident #142 was obtained from Physician. Staff were educated to ensure all patients scheduled for discharge had a discharge order in place. Attending physicians were reminded of the regulations regarding discharge summaries. Element Two - Identification of at-Risk Residents: All residents scheduled for discharge can be affected by this deficient practice. Element Three - Systemic Change: Staff were educated to ensure all patients scheduled for discharge have a discharge order in place. Attending physicians were reminded of the regulations regarding discharge summaries.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 661	Continued From page 53 management of care, with an Assessment Reference Date (ARD) of 8/13/23 Section C Cognitive Patterns and with a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, reflected that the resident's cognitive status was [redacted]. Further review of the most recent discharge return not anticipated MDS (DRNA/MDS) showed that Section A Identification Information included that the resident was Ex.Order 26.4(b)(1) [redacted] There was no physician order for the resident's transfer to another facility in the hybrid medical record (both electronic medical record (eMR) and the paper chart). On 9/21/23 at 01:39 PM, the surveyor in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the concern that there was no physician order for [redacted] that was obtained for Resident #84. The DON verified and confirmed that there was no written and transcribed order for Ex.Order 26.4(b)(1) [redacted] on the hybrid medical records. The DON stated that there should be an order from the physician. On 9/22/23 at 10:07 AM, the survey team met with the LNHA and the DON, and the surveyor notified the facility management of the above findings. On 9/25/23 at 10:35 AM, the survey team met with the LNHA and the DON. The LNHA stated that Resident # 84 was still within 30 days for the physician to do a Ex.Order 26.4(b)(1) but should have	F 661	Element Four - Quality Assurance: The Unit Manager/designee will conduct a weekly audit for one month and then monthly for two months for patients scheduled to be discharged to ensure a discharge order is in place. Results will be reported monthly to the QAPI team for review and revision. A weekly audit will be conducted for one month and then monthly for two months by the MDS Coordinator/designee to ensure that the attending physicians complete discharge summaries within thirty days. Results will be reported monthly to the QAPI team for review and revision.	

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 661		F 661		

Continued From page 54

an order for transfer to another facility.

2. The surveyor reviewed the medical records of Resident #142.

The AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted]

The aMDS with an ARD of 8/02/23 showed a BIMS score of [redacted] out of 15 which indicated that the resident's cognitive status was [redacted].

Further review of the DRNA/MDS showed that Section A included that the resident was [redacted]

There was no physician order for the resident's transfer to another facility in the hybrid medical records.

On 9/21/23 at 12:54 PM, the surveyor met with the DON and the LNHA in the presence of the survey team. The surveyor asked the facility management about the facility's process of discharging residents to another facility. The DON stated, that the nurse will call the doctor to get an order for the transfer to another facility, which should be transcribed to eMR the order for [redacted]. The DON further stated that the Ex.Order 26.4(b)(1) was done by a physician, then a nurse will write when the resident was Ex.Order 26.4(b)(1) The DON informed the surveyor that it was the

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 661	Continued From page 55 physician's responsibility to write the summary of the resident's stay in the facility including the diagnosis and what was done to the resident at the facility. On that same date and time, the DON stated that the physician should write the Ex.Order 26.4(b)(1) [redacted] at the time of Ex.Order 26.4(b)(1) and shortly after. The DON further stated that the physician can write the order for Ex.Order in either paper or electronic order. At that same time, the DON checked and verified the hybrid medical records for the physician's Ex.Orde [redacted] The DON confirmed that there was no order for transfer to another facility and no physician's Ex.Order 26.4(b)(1). Both the LNHA and the DON acknowledged that it should have been done. A review of the facility's Discharge Planning Policy that was provided by the DON with a revised date of 3/29/23 included that Goal: the resident's needs pertaining to post-discharge care will be assessed upon admission. The IDCP team members will perform the assessment. A plan to meet these needs will be developed and interventions to meet specific d/c planning goals will be designed. The plan will be monitored and revised as necessary throughout the nursing home stay. Process: at the time of admission the following tasks will be accomplished by the following disciplines indicated if necessary. 1. Admissions will notify all departments of a resident's admission status, i.e. short -term or long-term. 2. IDCP team will meet within 72 hours after the admission of a short term resident to discuss placement status. Care plans will be written for each of the identified residents which	F 661		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 661	Continued From page 56 shall include the problem, goals, and interventions. ...7. The discharge planning process will begin with the pre-admission screen review and the *Ex Order 26. 4B1* Schedule which are communicated to the whole IDCP team. 9. The Physician Discharge Summary will be completed within thirty days are the resident has been permanently discharged from the facility. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings. NJAC 8:9-36.1(b), (c)	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676		10/12/23

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 676	Continued From page 57 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a Ex.Order 26.4(b)(1) for a resident identified as having Ex.Order 26.4(b)(1) This deficient practice was identified for one (1) of one (1) resident (Resident #39) reviewed for Ex.Order 26.4(b)(1) and was evidenced by the following: On 9/18/23 at 10:54 AM, the surveyor observed the resident lying in bed, who waived to the surveyor. The surveyor observed the menu in the Resident's room was written in both English and Ex.Order 26.4(b)(1). The English Activities Communication Calendar in Resident #39's room was dated September 2023, and the Ex.Order 26.4(b)(1) Activities Communication Calendar was dated June 2023.	F 676	Element One - Corrective Action: It is the practice of the Center to ensure that all residents with a Ex.Order 26.4(b)(1) have a Ex.Order 26.4(b)(1). The calendar in Resident #39's room was immediately replaced with the appropriate language calendar. An audit was conducted on all resident calendars, and no further issues were noted. The Activities Director was re-educated immediately to ensure monthly calendars were placed in appropriate rooms. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #39. All residents with Ex.Order 26.4(b)(1) have the potential	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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 676	Continued From page 58 On 9/18/23 at 12:08 PM, the surveyor called the family for interview and did not receive a response. On 9/19/23 at 10:40 AM, the resident was observed lying in bed, waived to the surveyor and pulled the blanket over his/her shoulders. The surveyor reviewed the medical records for Resident #39. The resident's Admission Record (an admission summary) reflected that Resident #39 was admitted to the facility with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted] According to the quarterly Minimum Data Set, (qMDS), an assessment tool used to facilitate the management of care dated 7/27/23, with a Brief Interview for Mental Status score of [redacted] out of 15, indicating that the resident had a Ex Order 26. 4B1 [redacted]. Further review of the qMDS section A. 1100 revealed the resident needed or wanted an interpreter to communicate with doctor or health care staff. A review of the Care Plan (CP) included a focus that indicated the resident had a diagnosis of Ex Order 26. 4B1 initiated and revised on 12/10/23. The interventions included use Ex.Order 26.4(b)(1) [redacted] with resident. Repeat as needed.	F 676	to be affected. Element Three - Systemic Change: The Administrator/Designee met with the Activities Director and Activities Staff to identify how monthly calendars are provided to each resident. Activity staff were re-educated to ensure monthly calendars were placed in appropriate rooms. Element Four - Quality Assurance: An audit will be conducted by the Activities Director/Designee weekly for two months to ensure all residents have the appropriate calendar. Results will be reported monthly to the QAPI team for review and revised as necessary.	

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 676	Continued From page 59	F 676		

Further review of the CP reflected a focus that Resident #39 participated in daily activities provided, initiated on 6/07/21, and revised on 5/12/22. The interventions included, provide a monthly activity schedule initiated on 6/07/21, and revised on 5/12/22.

A review of the Form CMS-672 (a standard form from Centers for Medicare and Medicaid Services) submitted by the facility revealed under section F142 that there were Zero residents in the facility that utilized Ex.Order 26.4(b)(1) [redacted]

On 9/20/23 at 10:51 AM, the surveyor interviewed the Recreation Director (RD) who stated she had worked in the facility for five weeks but had over 20 years of experience. The RD explained that the activities for the English and Ex.Order 26.4(b)(1) speaking residents occurred simultaneously in the Dining area. Both programs followed the same calendar.

At that time, the RD informed the surveyor that the Activities Communication Calendars were posted every first of the month by her and her staff. The calendars were available in English and Ex.Order 26.4(b)(1) [redacted] which were both placed in the Ex.Order 26.4(b)(1) speaking resident's rooms.

At that time, the RD stated the Recreation Aid who spoke Ex.Order 26.4(b)(1) would enter each of the Ex.Order 26.4(b)(1) speaking resident's room and remind the Resident of the day's activities schedule. "My team and I would ask the resident if they will be attending".

On 9/20/23 at 11:43 AM, during a follow up interview with the surveyor, the RD stated she

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 676	Continued From page 60 posted the calendars in each of the resident's room. At that time, the surveyor and the RD entered Resident #39's room to review the calendars posted on the walls. The surveyor asked the RD to step outside the resident's room to discuss. At that time, the RD confirmed the Activities Communication Calendar in English was dated September 2023, while the Ex.Order 26.4(b)(1) was dated June 2023. At that time, the RD stated she missed it along with everyone else (recreation aid and nurses) who had the opportunity to observe it and missed it since June 2023. The RD stated that the accurate date [month] on the Activities Communication Calendar was important for the resident's reality orientation. "It will take time to train". On 9/22/23 at 10:09 AM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding the two different dates for the Activities Communication Calendar for Resident #39, with the Ex.Order 26.4(b)(1) Activities calendar that was not updated since June 2003, and its possible effects on the residents time orientation and emotions. On 9/25/23 at 10:36 AM, during a meeting with the survey team, and the DON, the LNHA stated an audit for the calendars were conducted, the calendar was replaced and a Quality Assurance and Performance for Improvement (QAPI; a data driven and proactive approach to quality	F 676		

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 09/28/2023

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 676	Continued From page 61 improvement that included QA and Performance Improvement to ensure services are meeting quality standard and assuring care reached a certain level) was initiated after surveyor's inquiry. A review of the facility provided policy Activity Program revised August 2006 included under Policy Statement, Activity programs designed to meet the needs of each resident are available on daily basis. The Policy and Interpretation and Implementation included under section 6. Scheduled activities are posted on the resident bulletin board. Activity schedules are also provided individually to the residents who cannot access the bulletin board (e.g. Bed bound or visually impaired residents). A review of the Recreation Director job description dated 9/21/23 included under Job Responsibilities and Standards section 8. Prepares and posts are written monthly activity schedule for their area, and section 13. Oversees the over-all performance of the recreation staff for this area. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings.	F 676		
F 684 SS=D	NJAC 8:39-27.1 (a) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		10/12/23

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 09/28/2023

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

(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 684	Continued From page 62 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on the interviews, review of the facility closed record, and the review of facility provided documents, it was determined that the facility failed to: a) follow the physicians' orders for consultation for two (2) of 22 residents (Residents# 12 and #89) and b) ensure that the physician documented a recapitulation (a summary) of resident's stay at the facility and visit progress notes in accordance with the resident's care and professional standards of clinical practice for two (2) of 22 residents, (Residents#12 and #89) reviewed for quality of care and 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:	F 684	Element One - Corrective Action: It is the practice of the Center to ensure that all physician orders for consultations are followed, that a discharge summary of the resident's stay at the facility is completed, and physician visit progress notes are in accordance with the resident care and professional standards of clinical practice are reviewed for quality of care. Physicians were immediately re-educated and reminded of the regulations regarding monthly visits and discharge summaries. All nurses were re-educated immediately to ensure all physician orders were entered in the electronic record and followed through. Element Two - Identification of at-Risk Residents: This standard was not met for Residents #12 and #89. Residents #12 and #89 have been discharged from the facility. All residents at the facility have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Administrator/Designee, DON/Designee, Unit Manager/Designee, and MDS Coordinator/Designee met to review requirements and current procedure. The 24-hour report will be	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 684	Continued From page 63 "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." According to the N.J. Admin. Code § 8:85-2.3, Current through Register Vol. 54, No. 42, September 18, 2023, Section 8:85-2.3 - Physician services included: 2. The attending physician shall also be responsible for initial and ongoing medical evaluation, as follows: i. The medical assessment of the Medicaid beneficiary shall begin at the time of admission to a NF and shall be the foundation for the planning, implementation, and evaluation of medical services directed toward the care needs of the resident. ii. The medical assessment shall consist of the complete, documented, and identifiable appraisal (from the time of admission to discharge) of the Medicaid beneficiary's current Ex Order 26. 4B1 and Ex Order 26. 4B1 status. The medical assessment shall be utilized to determine the existing and potential requirements of care. The evaluation of the data obtained from the medical assessment shall lead to the development of the medical services portion of the interdisciplinary care plan. The assessment data shall be available to all staff involved in the care of the resident. iii. The tools utilized in the assessment process shall include a complete history and physical examination, eliciting medically defined conditions and prior medical history, admission form(s),	F 684	reviewed during the Morning Meeting to ensure that consultations are addressed, and appointments are scheduled and documented. Element Four - Quality Assurance: A weekly audit of four charts will be conducted for one month and then monthly for two months by the MDS Coordinator/designee to ensure that the attending physician's complete discharge summaries within thirty days and monthly visit progress notes are reported and documented. Results will be reported monthly to the QAPI team for review and revision. A weekly audit will be conducted for one month and then monthly for two months by the Unit Manager/designee to ensure the consultant physician orders have been scheduled and documented. Results will be reported monthly to the QAPI team for review and revision as necessary.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 684	Continued From page 64 transfer form(s), HSDP, and data from other members of the interdisciplinary team. 3. Physician progress notes shall: i. Be maintained in accordance with accepted professional standards and practices as necessitated by the Medicaid beneficiary's medical condition; ii. Be a legible, individualized summary of the Medicaid beneficiary's medical status and reflect current medical condition, including clinical signs and symptoms; significant change in physical or mental conditions; response to medications, treatments, and special therapies; indications of injury including the date, time and action taken; medical necessity for extent of change in the medical treatment plan; and iii. Be written, signed, and dated at each visit. 1. The surveyor reviewed the medical records of Resident #12 as follows: According to the Admission Record (AR; or face sheet; an admission summary), Resident #12 was admitted to the facility with a diagnosis that was not limited to *Ex Order 26. 4B1* [redacted]. The most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the	F 684		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 684	Continued From page 65	F 684		

management of care with an ARD (assessment reference date) of 8/13/23 on Section C Cognitive Patterns showed that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which reflected that the resident's cognitive status was *Ex Order 26. 4B1* .

Further review of the MDS showed that the last MDS that was done for the resident on Section A Identification Information included that Resident #12 had an unplanned [redacted] to an [redacted] .

A review of the Physician's Orders (PO) dated 7/24/23 handwritten orders of the Medical Doctor (MD) showed an order for a [redacted] *Ex Order 26. 4B1* consult *Ex Order 26. 4B1* [redacted] for *Ex Order 26. 4B1* [redacted] to rule out (r/o) GI *Ex Order 26. 4B1* [redacted] consult for [redacted].

There was a Report of Consultation dated 9/07/23 in the paper medical record that was signed by Nurse Practitioner#1 (NP#1) with the following information:
Report requested regarding: [redacted] f/u (follow-up)
Signature of Attending Physician: blank
Findings: + (positive) *Ex Order 26. 4B1* [redacted]
Diagnosis: blank
Recommendations: *Ex Order 26. 4B1* [redacted] QID (four times a day), QID, if worsening pain, inform the clinic and will consider *Ex Order 26. 4B1* [redacted]

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 09/28/2023

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ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18 NEW BRUNSWICK, NJ 08901**

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F 684	Continued From page 66 abd. Further review of the above 9/07/23 [redacted] consult showed that the order on 7/24/23 of the MD for a [redacted] consult for [redacted] to r/o [redacted] was not followed. In addition, the attending physician (or MD) did not sign the report of consultation and there was no diagnosis included. Furthermore, there was no documentation that the 7/24/23 order for [redacted] consult was followed. There was no documentation as to why the order for a [redacted] consult was not followed. Review of the hybrid medical records (a combination of paper, scanned, and computer-generated records) revealed that the MD's paper visit notes were filed in the closed record that was provided by the Licensed Nursing Home Administrator (LNHA), and the last notes was dated 3/01/22. The MD's visit notes in the electronic medical record (eMR) were on 3/27/23. There were no other visit notes from the MD after 3/27/23 and the next visit notes were on 9/09/23, 9/10/23, and 9/11/23. MD had no visit notes or Progress Notes (PN) both in paper and eMR from April 2023 through August 2023. The September 2023 MD's PN in the eMR did not include the required progress notes that shall be consistently maintained in accordance with accepted professional standards and practices that indicate the resident's medical condition; individualized summary of the resident's medical status and reflect current medical condition, including clinical signs and symptoms; a significant change in physical or mental conditions; response to medications, treatments,	F 684		

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 09/28/2023

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 684	Continued From page 67	F 684		

and special therapies; indications of injury including the date, time and action taken; medical necessity for the extent of change in the medical treatment plan.

Further review of the eMR revealed that NP#2 initial PN was on 7/03/23. The succeeding PN in the eMR of NP#2 were on 7/07/23, 8/04/23, 8/14/23, 8/15/23, 9/08/23, and 9/15/23.

On 9/27/23 at 01:22 PM, the survey team met with the LNHA and the Director of Nursing (DON). The DON verified and checked that the hybrid medical records of the resident did not include the MD's visit and progress notes from April 2023 through August 2023. The DON acknowledged that the MD's eMR notes were not in compliance with the facility's practice and regulations about documentation.

On that same date and time, the surveyor notified the above findings and concerns regarding the 7/24/23 MD's PO regarding [redacted] and *Ex Order 26. 4B1* consults.

On 9/28/23 at 11:29 AM, the survey team met with the LNHA and the DON. The DON stated that she called the Licensed Practical Nurse/Unit Manager (LPN/UM) and the LPN/UM stated that she did not recall the orders on 7/24/23 about the [redacted] and *Ex Order 26. 4B1* consults and that was why it was not done.

2. According to the AR, Resident #89 was admitted to the facility with a diagnosis that was not limited to *Ex Order 26. 4B1* [redacted]

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 09/28/2023

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 684	Continued From page 68	F 684		

Ex Order 26. 4B1 [redacted].

The most recent qMDS with an ARD of 4/05/23 on Section C showed that the resident had a BIMS score of [redacted] out of 15 which reflected that the resident's cognitive status was *Ex Order 26. 4B1* [redacted].

Further review of the MDS showed that the last MDS that was done for the resident on Section A Identification Information included that Resident #89's discharge status was *Ex Order 26. 4B1*.

A review of the resident's medical records revealed that there was no physician's recapitulation of the resident's stay after the resident Ex.Order 26.4(b)(1).

The last PPNN in the eMR was dated [redacted] created and signed electronically by NP#2 which was a few weeks before the resident [redacted] There were no other documented notes from the MD and NP#2 after the 6/07/23 notes.

Further review of the medical records showed that the last monthly paper visit notes of the MD were on 3/01/22. The eMR revealed that NP#2 started to document visit notes from 4/28/23 through [redacted]. Both the 3/01/22 MD visit notes and the 4/28/23 through [redacted] visit notes of the NP met the progress notes requirements according to the regulations and standard of practice.

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 09/28/2023

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 684	Continued From page 69	F 684		

There were succeeding PNs from the MD from 4/14/22 through 5/30/23 which did not consistently include requirements according to the regulations that the progress notes shall be maintained in accordance with accepted professional standards and practices as legible, individualized summary of the status and reflect current medical condition, including clinical signs and symptoms; a significant change in physical or mental conditions; response to medications, treatments, and special therapies; indications of injury including the date, time and action taken; medical necessity for the extent of change in the medical treatment plan; and be written, signed, and dated at each visit.

The PO dated 9/20/22 that was handwritten and signed by the MD included an order for a Ex Order 26. 4B1 consult Ex Order 26. 4B1 for Ex Order 26. 4B1 Ex Order 26. 4B1 and Ex Order 26. 4B1 for Ex Order 26. 4B1. The PO was part of the paper medical record that was provided to the surveyor for review by the LNHA.

Further review of the paper medical record revealed a PO dated 11/07/22 for a Ex Order 26. 4B1 consult for Ex Order 26. 4B1 that was handwritten and signed by MD.

A review of the eMR showed that there was an order from the MD on 9/20/22 for a Ex Order 26. 4B1 consult for Ex Order 26. 4B1 and a Ex Order 26. 4B1 consult for Ex Order 26. 4B1 that was transcribed by Licensed Practical

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 70 Nurse#1 (LPN#1). A review of the PN in the eMR revealed the following: 1. 9/21/22 PN by the MD with a note text: [redacted] consult, [redacted] consult, and [redacted] consult. 2. Late Entry for an effective date of 11/07/2022 and created on 11/08/22 PN by the MD with a note text: Ex.Order 26.4(b)(1) [redacted] 3. 11/7/2022 PN by LPN#2 with a note text: MD in to see pt (patient) [redacted] appt (appointment) requested. Further review of the hybrid medical records showed that there was no documentation as to why the physician's order for [redacted] and [redacted] consults was not followed. On 9/22/23 at 01:40 PM, the surveyor notified the LNHA and the DON of the above findings. On 9/25/23 at 10:35 AM, the survey team met with the LNHA and the DON. The LNHA stated that the MD should have documented within 30 days the recapitulation of the resident's stay in the facility and this should have been followed for all residents who were discharged (d/c) from the facility including Resident #89 who [redacted] at the facility. On 9/25/23 at 12:15 PM, the DON stated that the resident had to go out for the [redacted] and [redacted] consults because. The DON confirmed after checking the medical records that there were no other [redacted] and [redacted] consult notes except for 3/02/20 for [redacted]	F 684		

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 09/28/2023

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ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18 NEW BRUNSWICK, NJ 08901**

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F 684	Continued From page 71 and 4/05/21 for neurologist. On that same date and time, the DON further stated that she did not know why the physician's order on 9/20/22 for Ex Order 26. 4B1 and Ex Order 26. 4B1 consults and the 11/07/22 order for Ex Order 26. 4B1 consult was not followed. On 9/26/23 at 9:26 AM, the surveyor interviewed the LNHA and the DON in the presence of the survey team. The LNHA acknowledged that the MD utilized hybrid medical records for visits and PN. The LNHA informed the surveyor that it was the facility practice and procedure that the physicians including the resident's MD to document visit notes in the eMR. Both the LNHA and the DON acknowledged that the eMR visit notes of the PMD should comply with the required documentation according to the regulation. At that same time, both the DON and the LNHA acknowledged that the provided printed MD's visit notes from 9/06/22 through 6/12/23 after the surveyor's inquiry were not all reflective of what the PMD wrote in the eMR progress notes and there were discrepancies. In addition, the DON stated that she followed up with the MD on his documentation when the resident Ex.Order 26.4(b)(1) According to the DON, the MD informed her (DON) that he did not write a recapitulation summary for the resident who Ex.Order 26.4(b)(1) because the Ex.Order 26.4(b)(1) was his Ex.Orde summary. The DON further stated that she educated the MD about the recapitulation summary and that it should have been done for Resident #89. A review of the provided QAPI (Quality Assurance	F 684		

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 72 Performance Improvement) that was provided by the Vice President of Clinical Services (VPoCS) dated 8/03/23 showed that the goal was that the attending MD will complete the resident's History and Physical in a timely manner as per regulations, NP will follow the resident plan of care at least monthly and/or as needed depending resident clinical status. Further review of the above QAPI showed that the facility did not identify the surveyor's findings and concerns. A review of the facility's Consultants Policy that was provided by the DON with a revised date of 3/29/23 included the goal that the facility uses outside resources to furnish specific services provided by the facility. Process: the facility may use needed outside resources to furnish specific services to residents and to the facility such personnel are employed on a consultant basis; consultant services may be utilized in the areas of physicians with specialties and radiologists and diagnostic; consultants provide the facility with written, dated and signed reports of each consultation visit such reports contain the consultant's recommendations, plan for implementation of his/her recommendations, findings, and plan for continued assessment. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and VPoCS. The facility management did not provide additional information and did not refute findings.	F 684		
F 689 SS=D	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		10/12/23

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 73 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review and review of other pertinent facility provided documentation, the facility failed to implement and document in the resident's care plan a new Ex.Order 26.4(b)(1) after each Ex.Order 26.4(order to prevent any additiona Ex.Order 26 for one (1) of one (1) resident reviewed for Ex.Order 26 (Resident #2). This deficient practice was evidenced by the following: On 9/18/23 at 11:09 AM, the surveyor observed Resident #2 seated in a Ex Order 26. 4B1 in the dayroom. Resident #2 did not speak English. The surveyor interviewed the resident via an interpreter that was an employee of the facility and the resident stated that he/she was very good. The surveyor reviewed Resident #2's medical record. The Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; Ex Order 26. 4B1	F 689	Element One - Corrective Action: The facility's practice is to ensure that the resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. An audit was completed immediately on all residents with multiple Ex.Order 26 in the last month to ensure an intervention was in place and on the care plan. Education provided to staff to ensure interventions are entered on to care plans. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #2. All residents who have had an accident have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Administrator/Designee, DON/Designee, and Unit Managers/Designee met to review the incident and accident report procedure. All incident and accident reports will be reviewed with the Interdisciplinary team	

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 09/28/2023

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

(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 689	Continued From page 74 condition characterized by Ex.Order 26.4(b)(1) especially with *Ex Order 26. 4B1* , and often with Ex.Order 26.4(b)(1) resulting from *Ex Order 26. 4B1* of the *Ex Order 26. 4B1* . Resident #2's significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/29/23, indicated a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which reflected that the resident's cognition was *Ex Order 26. 4B1* . Resident #2's Discharge Return Anticipated MDS, dated Ex.Order 26.4(b)(1) indicated the resident had one [redacted] with Ex.Order 26.4(b)(1). A review of Resident #2's individualized comprehensive care plan (CP) reflected a focused area with an initiated date of 12/18/20, at risk for [redacted] due to *Ex Order 26. 4B1* , Ex.Order 26.4(b)(1); [redacted] on 11/10/2022; [redacted] on 11/11/2022; s/p [redacted] 7/26 returned 7/26. The following interventions were included: Ex.Order 26.4(b)(1) Date Initiated: 12/18/2020 Ex.Order 26.4(b)(1) Date Initiated: 12/18/2020 Keep [redacted] within reach Date Initiated: 02/14/2023 Ex.Order 26.4(b)(1) Date Initiated: 07/26/2023 Ex.Order 26.4(b)(1) Date Initiated: 12/18/2020 Refer to the Ex.Order 26.4(b)(1) Plan of Treatment in the medical record for more detail	F 689	within 72 hours post fall/accident to ensure immediate interventions that were implemented are addressed and updated on the care plan, as well as any additional interventions needed. Element Four - Quality Assurance: An audit of two chart will be conducted weekly by the DON/Designee for three months to ensure residents with [redacted] have appropriate interventions in place and interventions are on the care plan. Results are to be reported at QAPI monthly.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 689	Continued From page 75 Date Initiated: 02/14/2023 Reinforce the need to [redacted] Date Initiated: 12/18/2020 [redacted] evaluation and treatment as ordered Date Initiated: 12/18/2020 [redacted] schedule ac (before meals), hs (at bedtime) and prn (as needed)-[redacted] Date Initiated: 07/26/2023 Resolved interventions included: RESOLVED: 7/[redacted] when in room Date Initiated: 07/19/2022 Resolved Date: 05/05/2023 RESOLVED: [redacted] Date Initiated: 05/08/2023 Resolved Date: 08/04/2023 RESOLVED: Reinforce [redacted] safety as needed such as[redacted] Date Initiated: 12/18/2020 Resolved Date: 02/14/2023 Further review of the CP showed that there were no new interventions implemented on or around the fall of 11/10/22 and 11/11/22. On 9/19/23 at 11:49 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) for incidents or investigations that occurred for Resident #2 during the last year. On 9/20/23 at 10:06 AM, the surveyor interviewed Resident #2's assigned Licensed Practical Nurse (LPN) regarding the process after a resident had a fall. The LPN stated that after the resident was assessed for[redacted] and family and physician was notified, an incident report is done. She added that an investigation is done if the [redacted] was unwitnessed and if it was witnessed ask the person what caused the [redacted] On that same date and time, the surveyor asked	F 689		

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F 689	Continued From page 76	F 689		

if a new intervention would be put in place on the CP and who would do that. The LPN stated that a new intervention would be put in place after a [redacted] but that she did not know who placed it on the CP. The LPN then stated that she knew that an intervention should be put in place as soon as possible. The surveyor then asked the LPN if Resident #2 had any [redacted] The LPN stated that she knew that the resident had recently [redacted] and was sent to the [redacted] and had a [redacted].

At the same time, the LPN further stated that the resident was on the other wing before and that she was not aware if the resident had any [redacted] prior to that. The surveyor asked the LPN to look at Resident #2's CP. The LPN confirmed that Resident #2's CP did not have any new interventions placed after the two [redacted] in November 2022.

On 9/20/23 at 10:19 AM, the Director of Nursing (DON) provided the surveyor with three incident/investigation reports that occurred in the last year. A review of the reports included the following:

[redacted] Incident Description: 6:10 p (PM) The interpreter informed nurse that resident was found sitting on floor ...resident was sitting on his/her [redacted] with his/her [redacted] down-also there was [redacted] on the floor. Notes: 7/20/23 Team met to discuss [redacted]. Resident#2 was attempting to [redacted] a room which resident thought was a [redacted] was performed ...found to have a [redacted] to his/her [redacted]. Resident#2 was sent to [redacted] for evaluation. 11/11/22 Incident Description: Was called to day room by another staff that resident is on the.

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F 689	Continued From page 77 Notes: IDC (Interdisciplinary) team met to review incident, Patient is Ex.Order 26.4(b)(1) with periods of Ex.Order 26.4(b)(1). During the day patient in the dayroom with activities for close monitoring, Ex.Order Ex Order 26. 4B1 screen order. 11/10/22 Incident Description: While passing out medications, nurse heard a noise in pt's (patient's) bathroom, went in there, found pt. lying on floor. Notes: IDC team Met to review incident, PTS (patient) is Ex.Order 26.4(b)(1) Ex Order 26. 4B1, reeducated pts (patient) on the importance of using his/her walking and call for help, Ex.Orde Ex Order 26. 4B1 screen order. On 9/20/23 at 01:28 PM, the surveyor interviewed the DON regarding the process of implementing a new intervention after a resident has a Ex.Orde. The DON stated that there should be an intervention put in place if something changed unless there was an isolated incident. The surveyor asked the DON if there should be a new intervention placed on the CP after a Ex.Orde. The DON stated that there should be an intervention close to the date [of the Ex.Order 2 The surveyor asked the DON what was the reason that a new intervention be implemented. The DON stated that a new intervention would be put in place to prevent a Ex.Orde in the future. On 9/20/23 at 01:31 PM, the surveyor interviewed the Assistant DON (ADON) regarding updating the CP after a resident has a Ex.Orde. The ADON stated that the Unit Manager (UM) would have a meeting and that the UM usually updated the CP. She added that the CP could also be updated by the ADON or DON. The surveyor asked the ADON if she recalled Resident #2's Ex.Order 2 that occurred in November 2022. The ADON stated that she did not remember.	F 689		

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F 689	Continued From page 78 On 9/20/23 at 01:37 PM, the surveyor interviewed the DON regarding Resident #2's CP. The DON confirmed that there were no new interventions added after the 11/10/22 and 11/11/22 [redacted]. The surveyor asked the DON what the expectation would be. The DON stated that the expectation was that there should have been an intervention after each [redacted]. On 9/22/23 at 10:38 AM, in the presence of the survey team, the surveyor notified the LNHA and DON the concern that Resident #2 did not have any new interventions put in place on the CP after the resident fell two times in November 2022. On 9/22/23 at 10:41 AM, the surveyor asked the DON for a policy for [redacted]. The DON stated that [redacted] was included in the accidents and investigations policy that was previously provided to the survey team. On 9/27/23 at 01:37 PM, in the presence of the survey team and LNHA, the DON stated that the interventions were listed on the incident report but they were not placed on the resident's CP. The DON stated that the interventions should have been placed on the CP. A review of the facility provided policy titled, "Accidents and Incidents-Investigating and Reporting" with a revised date of 5/18/2022 included the following: 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of accidents or incidents as appropriate. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: ...	F 689		

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F 689	Continued From page 79 k. Any corrective action taken; l. Follow-up information as applicable; ... n. Other pertinent data as necessary or required; ... 3 ...This individual will submit completed documents to the DON/designee and discuss the incident at the morning management meeting. 4. An investigation of incidents as appropriate will be completed. The policy did not include any information specific to falls. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings. N.J.A.C. 8:39-27.1 (a)	F 689		
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: a) monitor residents returning from the Ex Order 26. 4B1 center for Ex Order 26. 4B1 access site and vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and Ex Order 26. 4 , that indicate the state of a patient's Ex Order 26. 4B1 functions) and b) complete the	F 698	Element One - Corrective Action: It is the facility's practice to ensure that patients who require Ex Order 26. 4B1 services receive care that aligns with professional standards. The nursing staff was immediately educated on how to complete the Ex Order 26. 4B1 Communication Form correctly."	10/12/23

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F 698	Continued From page 80 Ex Order 26. 4B1 Communication Record (HCR), post dialysis treatment according to standard of practice, policy, and facility practice. The deficient practice was observed for one (1) of two (2) residents (Resident #7) reviewed for Ex Order 26. 4B1. 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 casefinding, 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 casefinding; 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 9/19/23 at 10:24 AM, the surveyor observed Resident #7 sitting on edge of the bed,	F 698	Element Two - Identification of at-Risk Residents: This standard was not met for Resident #7. Resident #7 remains in the facility with no ill effects. All residents receiving Ex Order 26. 4B1 services have the potential to be affected. Element Three - Systemic Change: The DON/Designee, ADON/Designee, and Unit Manager/Designee met to review the "Ex Order 26. 4B1 Communication Form requirements." The nursing staff was re-educated on how to complete the "Ex Order 26. 4B1 Communication Form correctly." The form is to be completed upon the resident's return from Ex Order 26. 4B1. Element Four - Quality Assurance: The Unit Manager/Designee will conduct an audit of four Ex Order 26. 4B1 residents weekly x3 for one month, then every two weeks for one month, and then monthly. The results of these audits will be reviewed during the monthly QAPI meeting for review and revision as deemed necessary.	

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F 698	Continued From page 81 completely dressed. The resident was interviewable. The resident stated that their [redacted] days were on Tuesdays, Thursdays, and Saturdays at around [redacted] On 9/19/23 at 9:05 AM, the surveyor reviewed the hybrid medical records (combination of electronic medical record and physical chart) of Resident #7. The Admission Record (or face sheet; admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to [redacted] A review of the Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care with assessment with a reference date (ARD) 6/25/23 showed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15, which indicated that resident's cognitive status was [redacted].	F 698		

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F 698	Continued From page 82	F 698		

A review of the care plan, last review dated 6/29/23, revealed resident #7 will have the consequences of [redacted] controlled at the highest level possible with the prescribed [redacted] regimen, date initiated 6/24/22 and revised on 7/04/23.

On 9/25/23 at 02:20 PM, the surveyor reviewed the [redacted] Communication Log (a binder on the unit which contains a resident's HCR forms) of Resident #7. The HCR (a facility form used to communicate the resident's status on [redacted] treatment days between the facility and the [redacted] center) contained three separate areas to be filled out; the top section was to be completed by the facility nurse prior to the resident leaving the facility for the [redacted] treatment, the bottom section was to be completed by the [redacted] center staff after treatment and in the top section, was post [redacted] vitals to be completed by the facility nurse upon the residents return to the facility.

The surveyor reviewed the HCR's from 9/16/23 to 9/23/23 which revealed that five (5) of five (5) dates had incomplete HCRs for Resident #7. The following dates were: 9/16/23, 9/19/23, 9/21/23, 9/22/23 and 9/23/23, five (5) of the five (5) days Resident #7 attended [redacted]. The facility return section for VS (vital signs) was not completed. The resident's weights were not filled out prior or post [redacted] five (5) of five (5) forms. [redacted] access section was left blank. The [redacted] unit section was completely blank on 9/23/23 upon the residents return.

On 9/27/23 at 02:09 PM, the Director of Nursing (DON) confirmed that the form should be completed upon the residents return to the

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F 698	Continued From page 83 facility. The DON added that it was a two-part form in case the resident did not return from [redacted] with the form. The Licensed Nursing Home Administrator (LNHA) provided the surveyor with the facility policy titled: [redacted] Policy". Initial or revision dates were not documented within the policy. The policy revealed: 9.) A communication book will be sent with the residents to [redacted]. Upon return from [redacted], the charge nurse will review and take note of any recommendations. 10.) Upon return from [redacted] the resident will be checked for the following: a) check [redacted] for [redacted], b) check for [redacted]. 14) document treatment and the resident's response in nursing summary and evaluation. The "Dialysis Communication Book Policy" was attached to the dialysis policy provided by the LNHA. During review, it was revealed: ~~It is the policy of the facility to have open and ongoing communication with dialysis centers treating our residents to help promote quality and continuity of care. 4) Pertinent information can include but is not limited to changes in medication, diet, complaints of pain, redness, swelling at the shunt, changes in bruit, weight, change in vital signs. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings. N.J.A.C. 8:39-2.7(a)	F 698		

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F 725	Continued From page 84	F 725		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure residents' highest practical wellbeing by failing to: a.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of	F 725	Element One - Corrective Action: The facility's practice is to ensure staffing ratios are met and that all shifts are staffed to provide residents with daily living activities. This standard was not met on: a) 14 14-day shifts were found to be	10/12/23

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F 725	Continued From page 85 New Jersey (NJ) and b.) ensure that 7 AM-3 PM, 3-11 PM, and 11-7 shifts were staffed to provide the ADLs *Ex Order 26. 4B1* [redacted] for three (3) of 16 residents, (Residents#2, #35, and #67) according to facility practice, required minimum direct care staff-to-shift ratios as mandated by the state of NJ, and facility assessment. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. On 9/25/23 at 6:38 AM, the surveyor in the presence of another surveyor interviewed the 11-7 shift Licensed Practical Nurse#1 (LPN#1) from [redacted] Wing who informed the surveyors that	F 725	non-compliant with certified nursing assistant-to-resident ratios. On 9/3/23, 9/4/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/11/23, 9/12/23, 9/13/23, 9/14/23, 9/15/23, 9/16/23, the center did not meet the 8 to 1 ratio for dayshift staffing. All residents have the potential to be affected by this deficient practice. b) 1 of 14-night shifts were found to be non-compliant with certified nursing assistants to resident ratios. On 9/3/23, the center did not meet the 14 to 1 ratio for night shift staffing. Additional Staff were added to the schedule in case of call outs. The Staffing Coordinator/Designee will complete a weekly projected outlook on census and staffing to review resident-to-staff ratios. Staffing ratios are calculated daily and use of overtime and agency staff will be utilized as needed. The results of this review will be reported during the monthly QAPI meeting and revised as deemed necessary. Recruiting and retention of CNAs will continue as described above. Element Two - Identification of at-Risk Residents: Residents #2, #35, # 67 remain in the facility with no ill effects. All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Staffing Coordinator/Designee will complete a weekly projected outlook on census and staffing to ensure that resident-to-staff ratios are met. This	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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 725	Continued From page 86 she had been working in the facility for seven years, a regular shift 3-11 shift nurse and also works other shifts according to her availability. On that same date and time, LPN#1 informed the surveyor that there were two CNAs "last night" for the 11-7 shift with one call-out. The LPN stated that there should be three aides in the unit. She further stated that there was no nursing supervisor in the 11-7 shift and there had been no supervisor, for how long no supervisor, the LPN cannot remember. The surveyor asked for a copy of the 11-7 shift assignments including Saturday (9/23/23) and Sunday (9/24/2) and she stated that she would get back to the surveyor. On 9/25/23 at 6:42 AM, the surveyor interviewed the 11-7 shift nurse from the [redacted] Wing. LPN#2 informed the surveyor that she was an agency nurse and this was her first day to work at the facility. The LPN stated that the [redacted] Wing census (total count of residents) was 45, two CNAs, and one LPN (herself), and that there was no nursing supervisor. On that same date and time, the surveyor asked LPN#2 where were the two aides in the unit, and LPN#2 responded that one aide was in the dining area and she was not sure where the other aide was. The LPN further stated that the morning care and personal care of all residents in the unit were done. At this time, the surveyor observed CNA#1 in the dining area with her bag and sweater on walking around.	F 725	weekly projected outlook will allow us to schedule additional staff in case of call outs on days where staff mandated ratios have not been met. Audits of staffing ratios will be completed five times per week and addressed as they are discovered. Element Four - Quality Assurance: Audits of staffing ratios will be completed five times per week for four weeks, and then two weekly audits will be done weekly for the second month. The results of these audits will be reviewed during the monthly QAPI meeting for review and revision as deemed necessary.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 725	Continued From page 87	F 725		

Also, the surveyor observed Resident #67 in the dining area seated in their Ex Order 26. 4B1, well-dressed and clean. Resident #67 was from Ex Order 26. Wing.

On 9/25/23 at 6:44 AM, the surveyor observed Resident # 2 in their room lying on the bed with eyes closed. The resident was covered with a blanket, the resident was clean, and no smell of urine inside the room.

On 9/25/23 at 6:46 AM, the surveyor interviewed the 11-7 CNA from the Ex Order 26. wing in the hallway going to the dining area. CNA#1 informed the surveyor that she had been the CNA at the facility for a year. CNA#1 was unable to state the Ex Order 26. Wing census and how many residents she took care of for the 11-7 shift. She further stated that she took care of all residents on her assignment and that there was one nurse in the unit.

At that same time, CNA#1 was not aware of the nurse staffing ratio. She indicated that in the Ex Order 26. wing, usually there a three aides assigned but last night two CNAs worked. She further stated that she was not "sure" if there was a call-out. CNA#1 informed the surveyor that she did not have a regular assignment and that she works all shifts and different wings depending on the availability, and she claimed that she was a per diem CNA.

In addition, CNA#1 was unable to state the name and whereabouts of the other aide in the Ex Order 26. Wing unit. The surveyor was unable to see the other aide in the unit.

On 9/25/23 at 6:53 AM, the surveyor went to Ex Order 26. Wing room 25 and observed Resident # 35

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 09/28/2023

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F 725	Continued From page 88	F 725		

lying on the bed. The surveyor asked the resident if he/she was cleaned by the aide today and she stated [redacted] The resident did not have a complaint about care. The surveyor observed the resident clean and no smell of urine inside the resident's room

A review of the provided [redacted] wing assignments for the 11-7 shift (9/24/23) showed that LPN#2 was the nurse, CNA#2 had a total of 23 residents, and CNA#1 had a total of 24 residents.

A review of the provided [redacted] wing assignments for the 11-7 shift (9/24/23) LPN#1 was the assigned nurse, CNA#3 had a total of 25 residents, and CNA#4 had a total of 20 residents.

Further review of the provided Master Copy for staff assignment for 9/24/23 (Sunday) that was provided by the Director of Nursing (DON) included the following:

[redacted] Wing: 7-3 Shift assignment 1 CNA:15 residents, assignment 2 CNA:14 residents, and assignment 3 CNA:18 residents. 3-11 Shift assignment 1 CNA:23 residents and assignment 2 CNA:24 residents.
[redacted] Wing: 7-3 Shift assignment 1 CNA:24 residents and assignment 2 CNA:23 residents. 3-11 Shift assignment 1 CNA:23 residents and assignment 2 CNA:23 residents.

On 9/25/23 at 7:30 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and DON in the presence of another surveyor. The surveyor notified the facility management about the findings above. The DON stated that it was an expectation that all staff should be at the unit until 7 AM. The DON further

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 725	Continued From page 89	F 725		

stated that there was no supervisor for the 11-7 shift and that was been the staffing for the 11-7 shift. The DON indicated that one nurse in each unit and three aides in each unit for staffing for 11-7.

On that same date and time, the DON stated that weekend staffing varies and they (facility management) were aware of the weekend short staffing. She further stated that she would get back to the surveyor as to why CNA#2 was not in the [redacted] wing before the 7 AM shift ended.

On 9/25/23 at 10:35 AM, the survey team met with the LNHA and the DON. The DON stated that CNA#2 left at 6 AM. The surveyor asked the facility management why the nurse and the aide in the [redacted] unit were not aware that CNA#2 left at 6 AM, and who covered for CNA#2's assignment. The DON stated that she will get back to the surveyor.

On 9/25/23 at 12:15 PM, the DON provided a copy of an updated *Ex Order 26. 4B1* wing census of residents as follows:

[redacted] wing 11-7 shift of 9/24/23 census=45
[redacted] wing 11-7 shift of 9/24/23 census=44

At the same time, the DON stated that the two-bed hold was added to the census which was why the census was 91 instead of 89 and there was a discrepancy on previously submitted assignments from the *Ex Order 26. 4B1* wing. The DON acknowledged that they were aware of the mandated staffing law and based on the provided assignments on 9/24/23 for weekend staffing and observed by the surveyor on 9/25/23 for the 11-7 shift, the facility was not in compliance with the

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 725	Continued From page 90 staffing. 2. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 9/03/23 to 9/16/23 for the standard survey, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on one (1) of 14 overnight shifts as follows: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -09/03/23 had 6 CNAs for 92 residents on the day shift, required at least 11 CNAs. -09/03/23 had 6 total staff for 92 residents on the overnight shift, required at least 7 total staff. -09/04/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -09/05/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/06/23 had 6 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/07/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/08/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/09/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -09/10/23 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. -09/11/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. -09/12/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/13/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs.	F 725		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 725	Continued From page 91 -09/14/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/15/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/16/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. On 9/19/23 at 10:32 AM, during an interview with the surveyor, CNA#5 stated the following: The census for the [redacted] wing was 45. There were two (2) nurses on duty with three (3) CNAs including herself. CNA stated she knew the ratio was supposed to be one (1) CNA for every eight (8) residents on the 7AM to 3PM shift. The CNA explained that there were four (4) CNAs scheduled that day, but one (1) CNA had called out from work which was the reason for the (3) CNA on that shift. At that time, LPN#3 stated she too was aware of the mandated ratio of one (1) CNA to eight (8) residents on the 7 AM to 3 PM shift. The management was aware of the CNA who called out from their morning shift at work, but it was too short of a notice to get another person to cover their shift. At that time, CNA#5 stated it was hard to complete her assignments, but we get the work done. The surveyor reviewed the staff assignment sheet dated 9/19/23 that reflected three (3) CNAs and two (2) nurses were assigned to 45 residents. On 9/25/23 at 7:30 AM, during the meeting with the surveyors, the LNHA and the DON stated that they were aware of very short staffing on weekends. The LNHA stated he was giving	F 725		

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F 725	Continued From page 92	F 725		

$75-$100 staffing bonuses. The surveyor also notified the facility management of the PBJ (payroll based journal; allows staffing information to be collected on a regular and more frequent basis than previously collected) report for low weekend staffing.

On 9/25/23 at 10:10 AM, the Human Resource Director (HRD) informed the surveyors that the payroll time clock (an electronic based system that recorded when a staff clocked in for their shift and clocked out from their shift) was not working and was unable to provide the payroll staff report. The same report used for the PBJ required to be submitted to the Centers for Medicare and Medicaid Services (CMS). The HRD informed the surveyors that the payroll time clock was broken since 9/14/23. She had been manually entering the information into the payroll time clock.

On 9/25/23 at 10:36 AM, during a meeting with the surveyors, the LNHA and the DON, the surveyor discussed the staffing concerns.

At that time, during the meeting with the surveyors, and the DON, the LNHA showed the surveyors the recruiting binders he utilized as effort to staff the facility. "We are trying our best".

At that time, the LNHA stated he had just learned that morning that the payroll time clock was not working. The LNHA clarified that the employees including himself were able to clock in and out of the payroll time clock, and the issue was in the transmission of data.

On 9/26/23 at 9:38 AM, in the presence of the surveyors, and the LNHA, the surveyor

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 725	Continued From page 93 interviewed the corporate Payroll Administrator (cPA) telephonically. The cPA informed the surveyors that she was made aware of the issue with the time clock on 9/22/23 The cPA explained that their vendor captured the data from the time clock and sent the data for PBJ reporting to CMS. The cPA confirmed she learned that the HRD was manually entering the staffs pay roll data, and the cPA told the HRD not to do that. The cPA stated that entering the payroll time clock data manually was manipulating the time clock, could be misconstrued as falsifying time submitted. At that time, The cPA stated she was working with the time clock software vendor to address the issue. A review of the facility provided policy; Staffing revised on 3/29/23, included: Goal: [Facility name redacted] will provide adequate staffing to meet needed care and services for our resident population. Process 1. [Facility name redacted] will maintain adequate staffing on each shift to ensure that our residents 's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outline on the resident's comprehensive care plan. 4. Our facility furnishes information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each shift during at least one (1) week of each	F 725		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 725	Continued From page 94 quarter to appropriate state agencies as required. Such work week is selected by the state survey agency. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings.	F 725		
F 732 SS=D	N.J.A.C. 8:39-27.1(a) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732		10/12/23

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 95 §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that the posted Resident Care Staffing Report (24-hour staffing report) was up to date and provided accurate information. This deficient practice was evidenced by the following: On 9/18/23 at 9:18 AM, the surveyors entered the facility and observed the posted 24-hour staffing report which was dated 9/15/23. The census listed was 90. The staffing report was not up to date and it was three days late. On 9/23/23 at 11:26 AM, the surveyors observed the posted 24-hour staffing report which was dated 9/19/23. The census listed was 91. The staffing report was not up to date and it was four days late. On 9/25/23 at 8:35 AM, the surveyor observed the posted 24- hour staffing report which was dated 9/22/23. The census listed was 90. The	F 732	Element One - Corrective Action: It is the practice of the Center to post accurate and up-to-date Nurse Staffing Information daily. This standard was not met on 9/18/23, 9/23/23, and 9/25/23. The census was immediately updated, and the NJ Staffing Website was corrected if there was an error. The Human Resources Manager was educated to ensure that beholds are omitted from the census on the daily Nurse Staffing posting. Element Two - Identification of at-Risk Residents: All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Administrator/designee will perform an audit five days per week for two weeks, then once monthly for two months to ensure that accurate information is posted daily. In addition, Nursing Staffing	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 732	Continued From page 96 staffing report was not up to date and it was three days late. On 9/25/23 at 10:36 AM, the Licensed Nursing Home Administrator (LNHA) provided copies of the facility daily census report from 9/15/23 to 9/25/23 and reflected as follows: Date 9/15/23; Census: 89 (not reflected, the posted census was 90) Date 9/16/23; Census: 91 Date 9/17/23; Census: 91 Date 9/18/23; Census: 91 Date 9/19/23; Census: 91 Date 9/20/23; Census: 91 Date 9/21/23; Census: 91 Date 9/22/23; Census: 90 Date 9/23/23; Census: 90 Date 9/24/23; Census: 90 Date 9/25/23; Census: 90 (not reflected, the posted census was 91) The surveyor compared daily census report to the 24-hour staffing report that was posted on 9/18/23, and 9/25/23. On both of the outdated 24-hour staffing report posted, the census listed was inaccurate. Further review of the 24-hour staffing report reflected the following: Date 9/22/23; No Registered Nurse (RN) was scheduled. Date 9/24/23; No Registered Nurse (RN) was scheduled. Date 9/25/23; No Registered Nurse (RN) was scheduled. On 9/25/23 at 9:50 AM, during an interview with the surveyor, the Human Resource Director (HRD) stated her responsibilities included	F 732	Information will be posted the night before the following day and adjusted accordingly. Element Four - Quality Assurance: The results of the audit will be discussed in the monthly QAPI meeting.	

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 09/28/2023

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 732	Continued From page 97	F 732		

on-boarding, orientation, in-services, and staffing. The HRD stated she was still under orientation by the outgoing Staffing Co-Ordinator.

At that time the HRD informed the surveyors that she reviewed the census and the scheduled staff per shift. The HRD was unsure if an RN was required to be on the schedule. The HRD informed the surveyors that she was aware of the following:
7-3 shift required 1 CNA (Certified Nursing Aid) for every 8 residents.
3-11 shift required 1 CNA for every 10 residents.
11 to 7 shift required 1 CNA for every 14 residents and the Licensed Practical Nurse (LPN) could help out the CNA in the evening.

At that time, the surveyor asked why there were no RN scheduled for the 9/22/23 9/24/23, and 9/25/23, the HRD did not respond to the question.

On 9/25/23 at 9:59 AM, during an interview with the surveyors, the CNA/Unit Clerk (UC)/ outgoing Staffing Co-Ordinator (SC) stated she scheduled CNAs, nurses and was training the HRD, but was not in-charge of posting the census and the staffing in the lobby that was the sole responsibility of the HRD.

At that time, the CNA/UC/ outgoing SC stated an RN should be scheduled but was only able to schedule employees who were available to work. Sometimes, she had to post the schedule without an RN, but I always informed the Director of Nursing.
The DON and I worked with three (3) agencies, although I am unable to authorize incentives without the authorization of the administrator or the owner. I was able to receive authorization, for

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 98	F 732		

example, in the last two weeks, I received approval for incentives.

On 9/25/23 at 10:10 AM, the surveyor and the HRD reviewed the 9/22/23, 9/24/23 and 9/25/23 together. The HRD stated she was unsure as to why there was no RN scheduled. The HRD explained that the census posted was obtained from the morning meeting. The HRD also stated that she took the daily staffing sheet and calculated the number of employees scheduled and entered the data onto the 24- hour staffing report.

At that time, the HRD confirmed there were no RNs listed on the 24-hour staffing report. The HRD compared the scheduled staff against the 24- hour staffing report and acknowledge she had made an error on the posting. The HRD stated she had categorized one (1) of the RN as a CNA.

At that time, the surveyor asked the HRD what the significance was of an RN not scheduled on the 24-hour staffing report. The HRD stated "I don't know the significance, why that is important." She further stated that the DON and the Minimum Data Set Coordinator were both an RN and works Monday through Friday. She indicated that the DON also comes in on weekends at times.

At that time the surveyor requested for the license verification for the LPN and the payroll time clock report.

On 9/25/23 at 10:19 AM, the HRD provided the surveyor a copy of the license verification for the RN who was mislabeled as a License Practical Nurse.

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 99 At that time, the HRD informed the surveyors that the payroll time clock (an electronic based system that recorded when a staff clocked in for their shift and clocked out from their shift) was not working and was unable to provide the payroll staff report. The same report used for the Payroll Based Journal (PBJ) required to be submitted to the Centers for Medicare and Medicaid Services (CMS). The HRD informed the surveyors that the payroll time clock was broken since 9/14/23. She had been entering the information into the payroll time clock. On 9/25/23 at 10:36 AM, during a meeting with the surveyors, the LNHA and the Director of Nursing (DON), the surveyor discussed the staffing concerns, the outdated 24- hour staffing report that was posted on 9/18/23, 9/23/23 and 9/25/23, the inaccurate census listed on 9/15/23 and 9/25/23, and the 24-hour staffing reports which did not include an RN on the schedule for 9/22/23, 9/24/23 and 9/25/23. At that time, the LNHA showed the surveyors the recruiting binders he utilized as effort to staff the facility. "We are trying our best". At that time, the LNHA and the DON stated they were not aware that bed holds should not have been included as part of the census in the facility. At that time, the LNHA stated he had just learned that morning that the payroll time clock was not working. The LNHA clarified that the employees including himself were able to clock in and out of the payroll time clock, and the issue was in the transmission of data.	F 732		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 100 On 9/26/23 at 9:38 AM, in the presence of the surveyors, and the LNHA, the surveyor interviewed the corporate Payroll Administrator (cPA) telephonically. The cPA informed the surveyors that she was made aware of the issue with the time clock on 9/22/23. The cPA explained that their vendor captured the data from the time clock and sent the data for PBJ reporting to CMS. The cPA confirmed she learned that the HRD was manually entering the staffs pay roll data , and the cPA told the HRD not to do that. The cPA stated that entering the payroll time clock data manually is manipulating the time clock, could be misconstrued as falsifying time submitted. At that time, the cPA stated she was working with the time clock software vendor to address the issue. No further data was submitted. A review of the facility provided policy; Staffing revised on 3/29/23, included: Goal: [Facility name redacted] will provide adequate staffing to meet needed care and services for our resident population. Process 1. [Facility name redacted] will maintain adequate staffing on each shift to ensure that our residents 's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services. 2. Certified Nursing Assistants are available on each shift to provide the needed care and services of each resident as outline on the resident's comprehensive care plan.	F 732		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 732	Continued From page 101 4. Our facility furnishes information from payroll records setting forth the average numbers and types of personnel (in full-time equivalents) on each shift during at least one (1) week of each quarter to appropriate state agencies as required. Such work week is selected by the state survey agency. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings. N.J.A.C. 8:39-41.2 (a)(b)(c)	F 732		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident's dietary preferences were consistently identified and implemented including the approprite hours of sleep snacks (HS snacks) for one (1) of 19 residents, (Resident #7) reviewed.	F 806	Element One - Corrective Action: It is the practice of the Center to ensure that all resident dietary preferences are honored. The Dietician immediately re-interviewed the resident, and Resident #7 food preferences were updated. The Dietician and Kitchen Manager were educated on obtaining and updating	10/12/23

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 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 806	Continued From page 102 This deficient practice was evidenced as follows: On 9/19/23 at 10:24 AM, the surveyor observed Resident #7 seated on the edge of their bed with breakfast tray on the bedside table. There were no visible menus in the room for the resident to review. The residents breakfast meal was on his/her bedside table, the ticket only read, scrambled eggs, double portion. The preference and the dislike columns were blank. On 9/19/23 at 10:24 AM, during the interview the surveyor asked the resident about how he/she like their breakfast tray? The resident stated, Ex Order 26. [redacted] The surveyor asked if the resident receives a bedtime snack? The resident responded, *Ex Order 26. 4B1* [redacted] On 9/22/23 at 9:20 AM, the surveyor interviewed the Registered Dietician (RD) who stated, "all of our residents are given the menu in their room, preset with alternates, the kitchen is on a (3) three-week cycle. Resident #7 is on a *Ex Order 26. 4B1* [redacted] Diet *Ex Order 26. 4B1* . The resident has not discussed with me about not liking his options or food. Everyone in the building gets an Hour of Sleep (HS) snack. On that same date and time, the RD informed the surveyor that Nursing is responsible to put in the order per the doctor or my communication recommendation sheets. She further stated that the floor staff and nurses hand the snacks out to the residents. The RD stated that the snacks are	F 806	resident preferences. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #7. All residents with dietary preferences have the potential to be affected by this deficient practice. Element Three - Systemic Change: An audit of four charts will be conducted by the Dietician/designee weekly for one month and then monthly for two months to ensure that residents have their dietary preferences honored. Element Four - Quality Assurance: Results will be reported monthly to the QAPI team for review and revision.	

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 09/28/2023

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ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18 NEW BRUNSWICK, NJ 08901**

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F 806	Continued From page 103 either cart blanche or prebagged for the [Ex Order 26. 4B1] or special requests. She further stated that "My motto is that they should receive any item they want but a smaller portion if they are a [Ex Order 26. 4B1]. The facility is very liberal." On 9/22/23 at 9:38 AM, the surveyor interviewed the Food Service Director (FSD). The FSD informed the surveyor that the current prebagged snack list we have for the offered HS snack in the system does not include Resident #7. Meaning he/she does not have a special request or a prebagged [Ex Order 26. 4B1] snack listed in the kitchen. At that same time, the FSD explained that the kitchen computer system and the facility documentation system "do not talk to each other." The FSD further stated that "the list I showed you is created by verbal communication, or a correspondence form provided by the RD with the resident's preferences." The surveyor asked the FSD if there is a par level list for the HS snack cart that goes to the floors? The FSD stated, "no, we put all snack items available in the kitchen or items that should be used based on expiration date, so food does go to waste." On 9/22/23 at 10:42 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated that an HS snack is an order that gets entered into the electronic ordering system for every resident by either a doctor's order or the communication form from the RD. She further stated that once that order is placed it generates a nurse sign off in the medication administration record for the nurse to sign off. The FSD stated that the HS snack is sent up on a cart from the kitchen for all the residents. Furthermore, the	F 806		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 806	Continued From page 104 FSD stated that the residents that have a special request or [Ex Order 26. 4B1] snack ordered come up in a labeled prepackaged bag. On 9/27/23 at 11:45 AM, the surveyor interviewed the FSD, are there smaller portion sizes like a ½ slice of pie or 1 cookie instead of 3 in a bag provided on that cart? The FSD responded, "no, we do put a slice of pie, pudding, cookies on there but it is a normal portion. The surveyor asked, are there other [Ex Order 26. 4B1] menu provided to the residents to pick their own food for the day or week? The FSD replied, "no, we only provide our 3-week cycle menu that has an alternate choice at the bottom, a Chinese food menu, and an always available menu. We do not have special [Ex Order 26. 4B1] diet menus such as renal or diabetic. The [Ex Order 26. 4B1] diet residents are controlled with a menu extension that the residents are not given. It is for the line staff to be able to adjust our 3-week cycle menu for what is in range for the [Ex Order 26. 4B1] diet. The menu extension shows that a renal resident can not have Orange Juice and we change it out for apple juice. "The surveyor asked, do the residents see that they are getting apple juice on the menus provided to them? The FSD replied," no." On 9/27/23 at 12:07 PM, during the interview of the surveyor with the resident , the resident stated, [Ex Order 26. 4B1] The surveyor observed at that time, the resident had a menu stapled to his bulletin board. When the surveyor inquired about it the resident stated, [Ex Order 26. 4B1] The surveyor asked the resident if he/she would	F 806		

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 806		F 806		

Continued From page 105

the see it? The resident stated, [redacted]. After the resident reviewed it, the resident stated, [redacted]

At that same time, the resident informed the surveyor that he/she did not know that there was an always available menu to choose from. The surveyor observed that the lunch ticket that was served at this time to the resident had preferences and dislikes written on it. The surveyor asked the resident if what was written was accurate. The resident stated, *Ex Order 26. 4B1* [redacted]

During an interview on 9/28/23 at 10:21 AM of the surveyor with the DON and LNHA, both the LNHA and DON acknowledged that there is a communication issue between the RD, Nursing and FSD for prescribed HS snacks for residents on a *Ex Order 26. 4B1* diet.

On 9/19/23 at 09:05 AM, the surveyor reviewed the electronic medical record and physical chart of Resident #7.

The Admission Record, (or face sheet; admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to *Ex Order 26. 4B1* [redacted] dependence on *Ex Order 26. 4B1*

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 806	Continued From page 106	F 806		

Ex Order 26. 4B1 [redacted].

A review of the Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care with assessment reference date (ARD) 6/25/23 showed that the resident's Brief Interview for Mental Status (BIMS) score was [redacted] out of 15, which indicated that resident's cognitive status was [redacted].

Further review of CMDS Section F0400-Preferences for customary routine and activities. It revealed that letter D.) how important is it to you to have snacks available between meals? Was coded as (1) one (Very important). A review of section I, Active diagnosis, it revealed under I2900 that the resident has Ex Order 26. 4B1 [redacted] (DM). A review of section K0510 revealed the resident has been on a Ex Order 26. 4B1 diet since in the facility.

A review of Resident #7's Care Plan (CP), revealed, a focus of "the potential for Ex Order 26. 4B1 related to (R/T) a diagnosis of [redacted]." Under goal, "resident will be free of adverse effects of Ex Order 26. 4B1 daily through the next review." Under interventions, "Provide ordered diet and encourage compliance if needed. Assist as needed. Date initiated 6/24/22. The care plan did not reflect the residents' preferences for his/her Ex Order 26. 4B1 diet or snacks.

A continued review of Resident #7's Care Plan

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 806	Continued From page 107	F 806		

(CP), revealed, a focus of "resident has a desire to Ex.Order 26.4(b)(1) he/she receives Ex Order 26. 4B1 diet for Ex.Order 26.4(b)(1)." Under goal, "will consume appropriate amounts of food to maintain target Ex.Order 26.4(b)(1)." Date initiated 6/26/22 revision on 7/31/23. Interventions reflected Ex.Order 26.4(b)(1) snack, dated 9/22/23 post surveyor inquiry.

The Interdisciplinary Care Team Conference (IDCP) reports with an effective date of 3/28/23 and 6/26/23 do not list any preferences in section E.) dietary note by the RD for the resident.

A review of the physician order list (POL)date range of 10/1/22 -9/30/23 revealed:
" Offer HS snack, for bedtime supplement; Active 9/20/23.
" Offer HS snack, for bedtime supplement; discontinued 10/1/22-10/6/22.
" Offer HS snack, for bedtime supplement; discontinued 10/13/22.
" Offer HS snack, for bedtime supplement; discontinued 11/14/22-12/31/22.

The HS snack was entered in the POL system after surveyor inquiry on 9/20/23, nine (9) months since the previous order was discontinued on 12/31/22. It did not reflect the resident's meal preferences or choices. It did not reflect a prebagged Ex Order 26. 4B1 HS snack order.

A review of the physician order set (POS) for diet revealed an active order with a start date 01/17/23 for Ex Order 26. 4B1 diet, regular texture, Ex Order consistency. It did not reflect the resident's meal preferences or choices. It did not reflect a prebagged Ex Order 26. 4B1 HS snack order.

A review of the Treatment Administration Record

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 09/28/2023

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 806	Continued From page 108 (TAR) from 6/01/23- 9/30/23 revealed, "offer HS snack" order date on 9/20/23 with nursing sign off started on 9/20/23. A review of policy and procedure "Ex Order 26. 4B1 Diets", dated 9/20/20, read as; When necessary, the facility will provide a Ex Order 26. 4B1 diet that is individualized to meet the clinical needs and desires of a resident to achieve outcomes /goals of care. Under the procedure section # 2) A list of approved /standard diets will be available for nursing staff, who will notify physicians of the diets available at the facility. Theses diets correspond with the Ex Order 26. 4B1 diets on the facility menu extension. A review of Interdisciplinary Care Planning Policy and Procedure, dated 3/29/23, read as: #11) Since the care plan is a dynamic document, in the interim between quarterly reviews, the IDC team MUST revise problems, goals, and interventions in response to changes in the needs of residents. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services for an Exit Conference. The facility management did not provide additional information and did not refute findings.	F 806		
F 812 SS=F	NJAC 8:39-17.4 (c), (e) 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,	F 812		10/12/23

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 09/28/2023

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(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 109 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 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 store foods, maintain sanitation in a safe, and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/18/23 at 10:15 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and observed the following: 1. In the freezer the surveyor found one opened box of breaded eggplant without an open and use by date. The interior bag holding the eggplant strips were opened and unlabeled. The FSD stated, "that the exterior of the box should be labeled with the open and used by date. She also stated, the interior bag once opened should be label and dated." 2. In the freezer the surveyor found one opened	F 812	Element One - Corrective Action: It is the practice of the Center to ensure that food is stored and maintained in a safe, sanitary, and consistent manner to prevent food-borne illness. All food found not to be labeled or open was immediately thrown out. Element Two - Identification of at-Risk Residents: This standard was not met by breaded eggplant found open and without a label, an unlabeled box of pancakes and an open box of strawberries without the complete date, and open blueberries stored in the freezer without a label. Water droplets were also noted in the food pan. All residents have the potential to be affected by these deficient practices. Element Three - Systemic Change: All unwrapped and undated items were discarded immediately. Education was	

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F 812	Continued From page 110 box of pancakes. The exterior of the box was labeled with 8/31 (no year was indicated). The FSD could not explain if 8/31 was a received on, used by, or open date. The interior bag holding 24 pancakes was opened and unlabeled. The FSD stated, "that the exterior of the box should be labeled with the open and used by date. She also stated, the interior bag once opened should be label and dated." 3. In the freezer the surveyor found one opened box of strawberries. The exterior of the box was labeled with 4/6 delivery date (no year was indicated). The interior bag was opened and unlabeled. The FSD stated, "that the exterior of the box should be labeled with the open and used by date. She also stated, the interior bag once opened should be label and dated." 4. In the freezer the surveyor found one opened box of blueberries without an open and use by date. The interior bag holding was opened and unlabeled. The interior bag was opened and unlabeled. The FSD stated, "that the exterior of the box should be labeled with the open and used by date. She also stated, the interior bag once opened should be label and dated." 5. During rounds with FSD, the surveyor observed four (4) six in food pans stacked together with water droplets on the interior of each one. The FSD stated, "these pans should have been dried thoroughly prior to putting them away to prevent infection and cross contamination while cooking". A review of "Rose Mountain Care Center Food Storage Procedure" provided by the FSD, indicated; #5) All food stored in refrigerator or	F 812	provided to dietary staff regarding the safe storage of food. A dating system was implemented to include open dates and used by dates, including the month day. QAPI was completed on 9/18/23 and presented to the surveyors. Element Four - Quality Assurance: An audit will be conducted by the Dietary Director/Designee of the entire freezer to ensure that all items placed in the freezer are properly labeled and dated. An additional audit of five food pans will be conducted by the Dietary Director/Desginee to ensure there is no water droplets present in the pans. These audits will be performed weekly for three months, and results will be reported monthly to the QAPI team for review and revision as necessary. Audit for water droplets in food pans.	

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F 812	Continued From page 111 freezer shall be labeled and dated and #8) Uncooked and raw animal products and fish shall be stored separately and below fruits, vegetables and other ready to eat foods. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings. NJAC 8:39-17.2(g)	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		10/12/23

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F 842	Continued From page 112	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 113 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain complete and accurate records for a resident. This deficient practice was identified for one (1) of 1 resident reviewed for Ex.Order 26.4(b)(1) (Resident #51) and was evidenced by the following: On 9/18/23 at 10:48 AM, the surveyor observed Resident #51 sleeping on their right-hand side and was covered with a thin blanket. The surveyor reviewed Resident #51's medical record. Resident # 51 was admitted to the facility with diagnoses that included unspecified Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1 . According to the quarterly Minimum Data Set, (qMDS), an assessment tool used to facilitate the management of care dated 7/21/23 with a Brief Interview for Mental Status score of [redacted] out of 15, indicating that the resident had a Ex Order 26. 4B1 [redacted].	F 842	Element One - Corrective Action: It is the practice of the Center to ensure that all resident records are complete and accurate. The Ex.Order 26.4(b)(1) Company was immediately notified, and all notes were provided to the Center. Education provided to staff to ensure that a progress note is entered after a Ex.Order 26.4(b)(1) visit. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #51. All residents who receive Ex.Order 26.4(b)(1) [redacted] have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Unit Manager/designee will conduct a weekly audit of two residents on hospice for one month and then monthly for two months to ensure that all documentation has been received from the Ex.Order 26.4(b)(1) companies. Element Four - Quality Assurance: Results will be reported monthly to the QAPI team for review and revised as necessary.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 842	Continued From page 114 A review of the Physician's Order included Hospice Care ordered on 4/18/23. A review of the Care Plan included a focus that included Resident #51's wishes for the Ex.Order 26.4(b)(1) [redacted] to complement the care at the facility which was initiated on 4/20.23, and the need due to *Ex Order 26. 4B1* [redacted], initiated on 4/20/23. A review of the interventions included the following: -Monitor Ex.Order 26.4(b)(1), call Physician as needed or recommended by Ex.Order 26.4(b)(1) [redacted] for treatment with Ex.Order 26.4(b)(1) [redacted] or alternative *Ex Order 26. 4B1* [redacted], initiated on 4/20/23. -Facilitate Ex.Order 26.4(b)(1) [redacted] visits, initiated on 4/20/23. A review of the Progress Notes (PN) revealed a late entry dated 8/30/23, Licensed Practical Nurse#1 (LPN #1) documented, the Certified Nursing Assistant (CNA) was attending to the resident called the nurse's attention to a *Ex Order 26. 4B1* [redacted] observed to the resident *Ex Order 26. 4B1* [redacted] .... MD and family member made aware. A review of the [Company name redacted] Ex.Order 26.4(b)(1) [redacted] communication dated 7/31/23, record included the following: - Resident's Name and Resident Number - Facility Name - Request for Recommendations made by - Resident's diagnosis - Current Treatment Regimen - Name of Symptoms - Recommendations - Recommendations made by - Date and time	F 842		

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F 842	Continued From page 115 - Signature - Recommendation received by with the nurse's signature. On 9/22/23 at 11:17 AM, during an interview with the surveyor, LPN #2 assigned to Resident #51, stated the Ex.Order 26.4(b)(1) visited every week and assessed the resident once a week. The Ex.Order 26.4(b)(1) [redacted] would speak with the nurses on duty and used the [company name redacted] Ex.Order 26.4(b)(1) communication record paper (HCR). The HCR was placed within the Resident's paper medical record. At that time, the surveyor and LPN #2 reviewed the paper medical record for Resident #51. The surveyor asked LPN #2 why there were no HCR on the paper medical record for August and September 2023. The LPN stated she did not know. At that time, during an interview with the surveyor, the LPN/ Assistant Director of Nursing (ADON)/ Infection Preventionist (IP) informed the surveyor that the expectation was that hospice would take over services for the resident and ensure the resident was comfortable. The facility assisted in the care for the resident. The nurses from Ex.Order 26.4(b)(1) [redacted] came once a week and communicated with us [the nurses] and documented the resident's needs. At that time, the LPN/ADON/IP informed the surveyor that the Unit Manager who was on vacation, was in-charge of ensuring that the hospice nurse left a documentation for the nurses. The LPN/ADON/IP acknowledged that without the HCR she could not be certain that the Ex.Order 26.4(b)(1) had visited to assess the resident's	F 842		

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F 842	Continued From page 116 needs. On 9/25/23 at 10:36 AM, during a meeting with the surveyors, the surveyor informed the Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON) regarding the concern of the missing communication records from Ex.Order 26.4(b)(1) for August and September 2023. At that time, the DON informed the surveyors that the expectation was that the Ex.Order 26.4(b)(1) would see the resident once or twice a weeks, speak with the nurses, assess the resident and document within their software and provide the facility a copy. The Nurses were expected to document in the PN, the interaction with the Ex.Order 26.4(b)(1), and what was communicated to them by the Ex.Order 26.4(b)(1). At that time, the DON informed the surveyors that the Unit Manager responsible for ensuring that the HCR was sent to the facility for Resident #51. "It should have been in the chart." On 9/27/23 at 01:45 PM during a meeting with the surveyor and LNHA, the DON confirmed no additional documents were available for review. A review of the facility provided document Ex.Order 26.4(b)(1) revised 3/29/23, included under Procedure section 4. During their time on Ex.Order 26.4(b)(1) [redacted] he Director of Social Services acts as the liaison between the resident, their representative, the facility and the Ex.Order 26.4(b)(1) agency and ensures Care Coordination. A review of the facility provided Ex.Order 26.4(b)(1) Agreement dated 10/01/2007, included under section IV. Records subsection 4.1 Preparation	F 842		

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F 842	Continued From page 117 and Contents Nursing Facility and [redacted] shall each prepare and maintain complete and detailed clinical records concerning each [redacted] Patient receiving services under this Agreement in accordance with prudent record-keeping procedures and as required by applicable federal and state law and regulations and applicable Medicare and Medicaid program guidelines. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings.	F 842		
F 883 SS=D	NJAC: 8:39-35.2(d)(5)(6) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		10/12/23

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F 883	Continued From page 118 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of other pertinent provided facility documents, it was determined that the facility failed to: a) identify a resident and offer a subsequent	F 883	Element One - Corrective Action: The Center's practice is to ensure that all residents who are due for the Ex.Order 26.4(b)(1) are offered	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 883	Continued From page 119 pneumococcal vaccine and b) revise the facility pneumococcal vaccine policy to reflect the current Pneumococcal vaccination guidelines in accordance with the CDC's (Centers for Disease Control and Prevention) guidelines for one (1) of five (5) residents, (Resident #14) reviewed for immunization. This deficient and was evidenced by the following: Reference: A review of the CDC guidelines for Pneumococcal vaccination included: For adults who only received the Pneumococcal polysaccharide vaccine (Pneumovax/PPSV 23) regardless of risk and condition, should received one (1) dose of Pneumococcal conjugate vaccine (PCV 15 or PCV20) at least one year after the most recent PPSV23. On 9/21/23 at 9:53 AM, the surveyor observed Resident #14 in the patio, light his/her cigarette and began smoking. The surveyor reviewed the medical records for Resident #14. The resident's Admission Record (an admission summary) reflected that Resident #14 was admitted to the facility with diagnoses that included but were not limited to *Ex Order 26. 4B1* [redacted].	F 883	the vaccine when it is due, and the immunization policy reflects CDC guidelines. A Vaccine tracking tool was immediately created, and policy was updated to reflect CDC guidelines. All residents due for the Pneumococcal Vaccine were provided with a 'Pneumococcal Vaccine Informed Consent' or 'Pneumococcal Vaccine Informed Declination' form. A doctor's order was obtained, and information was sent to the pharmacy. The Pneumococcal Vaccine was administered to the residents who consented when received from the pharmacy. The Infection Preventions was educated on ensuring that all residents receive the Pneumococcal immunization when due. Element Two - Identification of at-Risk Residents: This standard was not met for Resident #14. As per CDC guidelines, all residents who are due for their *Ex Order 26. 4B1* [redacted] have the potential to be affected. Element Three - Systemic Change: The Vaccine Tracking Tool will be reviewed weekly by Infection Prevention. The IP/designee will conduct an audit monthly to ensure that all residents who meet the CDC criteria for the *Ex Order 26. 4B1* [redacted] have it administered when it is due. Element Four - Quality Assurance: Results are to be reported monthly to the QAPI team for review and revised as	

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F 883	Continued From page 120 According to the most recent annual Minimum Data Set, (aMDS), an assessment tool used to facilitate the management of care dated 8/10/23, with a Brief Interview for Mental Status score of [redacted] out of 15, indicating that the resident was *Ex Order 26. 4B1*. Further review of the aMDS section O. 0300 *Ex Order 26. 4B1* revealed [redacted] the resident's *Ex Order 26. 4B1* was up to date. A review of the resident's *Ex Order 26. 4B1* record indicated the resident received a *Ex Order 26. 4B1* six years ago when the resident was less than 65 years of age. The immunization record did not show a subsequent immunization for *Ex Order 26. 4B1* was offered. On 9/22/23 at 11:44 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN)/ Assistant Director of Nursing/ Infection Preventionist stated she tracked the resident's immunization. On 9/22/23 at 12:34 PM, during a follow up interview with the surveyor, the LPN/ADON/IP stated she could not locate the *Ex Order 26. 4B1* tracking form she had. If it is not documented within the electronic medical record, under immunization, it was missed. On 9/25/23 at 10:36 AM, during a meeting with the surveyors, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concerns regarding the surveillance of Resident #14's *Ex Order 26. 4B1*, the resident's missed	F 883	necessary.	

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	315384	A. BUILDING _____ B. WING _____	C 09/28/2023

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F 883	Continued From page 121 subsequent Ex Order 26. 4B1 that should have been administered one year after the first Ex Order 26. 4B1, (received 6 years ago) and the concern regarding the facility policy. At that time, the DON stated, "We follow CDC guideline, and the Resident should have had another dose". On 9/25/23 at 11:43 AM, during a meeting with the surveyors, the LPN/ADON/IP stated the resident should have received another vaccination. Moving forward we would follow the guideline in a timely manner. The LPN/ ADON/ IP acknowledged that the immunization surveillance was inaccurate. A review of an undated facility provided policy Ex Order 26. 4B1 included: Purpose, all residents are provided the opportunity and encouraged to receive Ex Order 26. 4B1. Under General Information: Ex Order 26. 4B1 is given only one time. A review of another undated facility provided policy Ex Order 26. 4B1 included: Policy, it is the policy of this facility to document evidence of annual vaccination against Ex Order 26. 4B1 for all residents who are 65 years of age or older in accordance with the recommendations of the advisory committee on immunization practices of the Center for Disease Control most recent to the time of vaccination unless such vaccination is medically contraindicated, or the resident has refused offer of the vaccine ... On 9/28/23 at 01:30 PM, the survey team met	F 883		

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F 883	Continued From page 122 with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings. NJAC 8:39-19.4 (a) (i)	F 883		
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure facility staff had mandatory training that outlined and informed staff of the elements and goals of the facility's Quality Assurance and Performance Improvement (QAPI) program for five (5) of five (5) Certified Nurse Assistants (CNAs) reviewed for mandatory education. The deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files within a year according to their date of hire. A review of the facility form, Continuing Education Record for 2022 to 2023 revealed the log did not include the mandated QAPI education training for CNA#1, #2, #3, #4, and #5.	F 944	Element One - Corrective Action: It is the practice of the Center to ensure that all staff that are due for annual QAPI Training as part of the mandatory training for Certified Nursing Assistants receive it annually. QAPI was immediately added to the "Employee Education Log." The Educator was educated to ensure that the education log is reviewed monthly to ensure that required QAPI education is completed. Staff were provided with QAPI education. Element Two - Identification of at-Risk Residents: This standard was not met for CNA #1, #2, #3, #4, and #5. All CNAs and residents can potentially be affected by this deficient practice. Element Three - Systemic Change:	10/12/23

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F 944	Continued From page 123 On 9/27/23 at 12:06 PM, during an interview with the surveyor, the Licensed Practical Nurse / Assistant Director of Nursing (ADON) Infection Preventionist /Education Co-Ordinator (EC) stated she received an informal training from the previous ADON. At that time, the EC stated the QAPI education training was for the director and managers. "We have not done it for the CNAs, nurses or other staff." On 9/27/23 at 01:4 PM, during a meeting with the surveyors, the Licensed Home Nursing Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the missing in-services for the CNAs. On 9/28/23 at 11:32 AM, during a meeting with the surveyors and the DON, the LNHA stated moving forward we added the behavioral health training and Quality Assurance and Performance Improvement (QAPI) program. No additional information was provided. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings. N.J.A.C. 8:39-9.3(2),33.1	F 944	The Educator/Designee will conduct an audit monthly to ensure that staff are up-to-date with the mandatory annual education requirements. Element Four - Quality Assurance: Results will be reported monthly to the QAPI team for review and revision.	
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health.	F 949		10/12/23

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F 949	Continued From page 124 A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility failed to ensure the facility staff had the mandatory behavioral health training for two (2) of the five (5) Certified Nursing Assistants (CNA #3 and CNA #5) reviewed for mandatory education. The deficient practice was evidenced by the following: The surveyor requested five (5) random CNA education files within a year according to their date of hire. A review of the facility form, Continuing Education Record for 2022 to 2023 revealed the log did not include the mandated behavioral health education training for CNA#3 and #5. On 9/27/23 at 12:06 PM, during an interview with the surveyor, the Licensed Practical Nurse / Assistant Director of Nursing (ADON) Infection Preventionist /Education Co-Ordinator (EC) stated she received an informal training from the previous ADON. At that time, the surveyor and the EC reviewed the Continuing Education Record for the five (5) random CNAs. The EC opened a binder an showed the surveyor an In-Service (continuing education) attendance sign-in sheet for Caring for Combative and Confused Residents, October 2022.	F 949	Element One - Corrective Action: It is the practice of the Center to ensure that all staff members due for annual Behavioral Health Training as part of the mandatory training for Certified Nursing Assistants receive it annually. Behavioral Health Training was immediately provided to staff who did not receive it. Education was provided to the Educator to ensure that the education log is reviewed on a monthly basis to ensure that all staff have completed Behavioral Health Training. Element Two - Identification of at-Risk Residents: This standard was not met for CNA #3 and #5. All CNAs and residents can potentially be affected by this deficient practice. Element Three - Systemic Change: The Educator/Designee will conduct an audit of three staff members monthly to ensure that staff are up-to-date with the Behavioral Health Training requirements. Element Four - Quality Assurance: Results are to be reported monthly to the QAPI team for review and revised as necessary.	

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F 949	Continued From page 125 At that time, the EC confirmed with the surveyor that the signatures for CNA #3 and CNA #5 were missing. At that time, the EC stated they were using an electronic education module on-line but had since switched to paper. The EC stated she distributed the invites to the staff and the employee was able to log into the classroom under an indiscernible name or email. For those who attended the in-service who were not using their real name or last name, we had difficulty correlating which staff attended and received the in-service. "It made it difficult to track. It was not effective". At that time the EC confirmed to the surveyor that she was unable to provide documentation that CNA #3 and CNA #5 received the in-service. On 9/27/23 at 01:4 PM, during a meeting with the surveyors, the Licensed Home Nursing Administrator (LNHA) and the Director of Nursing (DON), the surveyor discussed the concern regarding the missing in-services for the CNAs. On 9/28/23 at 11:32 AM, during a meeting with the surveyors and the DON, the LNHA stated moving forward we added the behavioral health training and Quality Assurance and Performance Improvement (QAPI) program. No additional information was provided. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings.	F 949		

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F 949	Continued From page 126 NJAC 8:39-9.3(2), Appendix B XI-5	F 949		

New Jersey Department of Health

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	061204	A. BUILDING: _____ B. WING _____	C 09/28/2023

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of pertinent facility documentation it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse,	S 560	Element One - Corrective Action: The facility's practice is to ensure staffing ratios are met and that all shifts are staffed to provide residents with daily living activities. This standard was not met on: a) 14 of the 14-day shifts were found to be non-compliant with certified nursing assistant-to-resident ratios. On 9/3/23, 9/4/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/9/23, 9/10/23, 9/11/23, 9/12/23, 9/13/23, 9/14/23, 9/15/23, 9/16/23, the center did not meet the 8 to 1 ratio for dayshift staffing. All residents have the potential to be affected by this deficient practice. b) 1 of 14-night shifts were found to be non-compliant with certified nursing assistants to resident ratios. On 9/3/23	10/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/13/23

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S 560	Continued From page 1 licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the week of staffing from 9/3/23 to 9/16/23 for the standard survey, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -09/03/23 had 6 CNAs for 92 residents on the day shift, required at least 11 CNAs. -09/03/23 had 6 total staff for 92 residents on the overnight shift, required at least 7 total staff. -09/04/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -09/05/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/06/23 had 6 CNAs for 89 residents on the day shift, required at least 11 CNAs.	S 560	the center did not meet the 14 to 1 ratio for night shift staffing. The facility added extra staff on the schedule to meet ratios in case of call out. Element Two - Identification of at-Risk Residents: All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Staffing Coordinator/Designee will complete a weekly projected outlook on census and staffing to ensure that resident-to-staff ratios are met. This weekly projected outlook will allow us to schedule additional staff in case of call outs on days where staff mandated ratios have not been met. Audits of staffing ratios will be completed five times per week and addressed as they are discovered. Element Four - Quality Assurance: The results of these audits will be reviewed during the monthly QAPI meeting for review and revision as deemed necessary.	

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S 560	Continued From page 2 -09/07/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/08/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -09/09/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -09/10/23 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. -09/11/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. -09/12/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/13/23 had 8 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/14/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/15/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. -09/16/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. On 9/25/23 at 7:30 AM, during the meeting with the surveyors, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) stated that they were aware of very short staffing on weekends. The LNHA stated he was giving $75-$100 staffing bonuses. The surveyor also notified the facility management of the report for low weekend staffing. On 9/25/23 at 10:36 AM, during a follow-up meeting with the surveyors, the LNHA and the DON, the surveyor discussed the staffing concerns. At that time, during the meeting with the surveyors, and the DON, the LNHA showed the surveyors the recruiting binders he utilized as effort to staff the facility. "We are trying our best."	S 560		

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S 560	Continued From page 3 At that time, the LNHA stated he had just learned that morning that the payroll time clock was not working. The LNHA clarified that the employees including himself were able to clock in and out of the payroll time clock, and the issue was in the transmission of data. On 9/26/23 at 9:38 AM, in the presence of the surveyors, and the LNHA, the surveyor interviewed the corporate Payroll Administrator (cPA) telephonically. The cPA informed the surveyors that she was made aware of the issue with the time clock on 9/22/23 The cPA explained that their vendor captured the data from the time clock and sent the data for PBJ (payroll based journal; type of employee time in and out records reporting) reporting to CMS. The cPA confirmed she learned that the HRD was manually entering the staffs pay roll data, and the cPA told the HRD not to do that. The cPA stated that entering the payroll time clock data manually is manipulating the time clock, could be misconstrued as falsifying time submitted. At that time, the cPA stated she was working with the time clock software vendor to address the issue. No further data was submitted. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings.	S 560		

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S 830	Continued From page 4	S 830		
S 830	8:39-9.3(b) Mandatory Administration (b) The facility shall make reasonable efforts to ensure that staff providing direct care to residents in the facility are in good physical and mental health, emotionally stable, of good moral character, and are concerned for the safety and well-being of residents; and have not been convicted of a crime relating adversely to the person's ability to provide care, such as homicide, assault, kidnapping, sexual offenses, robbery, and crimes against the family, children or incompetents, except where the applicant or employee with a criminal history has demonstrated his rehabilitation in order to qualify for employment at the facility. ("Reasonable efforts" shall include an inquiry on the employment application, reference checks, and/or criminal background checks where indicated or necessary.) This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files, it was determined that the facility failed to obtain a Criminal Background (CB) check prior to the date of hire for new employees. This deficient practice was identified for four (4) of ten (10) newly hired employees reviewed and was evidenced by the following: A review of the ten randomly selected newly hired employee files included the following: Staff #5, a Registered Nurse (RN) prior Director of Nursing, hired 8/23/21, had a CB entered	S 830	Element One - Corrective Action: It is the practice of the Center to ensure that all employees have criminal background checks before hiring. A new qualified Human Resources Director was hired on August 21, 2023. Element Two - Identification of at-Risk Residents: Staff #5, #6, #8, and #9 did not meet this standard. All residents have the potential to be affected by this deficient practice.	10/12/23

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S 830	Continued From page 5 (ordered) on 8/24/21 and completed (reported) on 8/24/21. Staff #6, a Licensed Practical Nurse (LPN), hired 7/12/21, had a CB entered on 9/26/23 and completed on 9/26/23. Staff #8, a Certified Nursing Assistant (CNA), hired 7/26/22, had a CB entered on 8/31/23 and completed on 8/31/23. Staff #9, a Certified Nursing Assistant (CNA), hired 3/26/23, did not have a CB in their employee file. There was no documented evidence that a CB was done. On 9/28/23 at 9:44 AM, the surveyor interviewed the Human Resource Director (HRD) regarding the process for the background check of newly hired employees. The HRD stated that after the employee was interviewed, she would run a background check then if the background check was clear she would bring back the employee to do the physical, TB (tuberculin) testing and then fill out orientation packet. The surveyor asked when the date of hire was. The HRD stated that the hire date was once they clear everything. She added all should be done prior to the hire date and that date was when the employee started on the floor even if they were only shadowing another employee. On that same date and time, the surveyor asked when the HRD started at the facility. The HRD stated that she had started on 8/21/23. The surveyor asked the HRD if the employee files that were provided to the surveyor were the complete files. The HRD stated that she could not speak for someone else's work and that if the prior person went through her process that the files	S 830	Element Three - Systemic Change: An audit was completed by the Human Resources Director/Designee on all current employee files to ensure all background checks have been verified. The Human Resources Director/Designee will audit two new employee files weekly times two for three months to ensure background checks have been preformed prior to start date. Human Resources/Designee will submit new hire folders to the Administrator before the employee start date for verification of required documents. Element Four - Quality Assurance: Results are to be reported monthly to the QAPI team for review and revised as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061204	A. BUILDING: _____ B. WING _____	C 09/28/2023

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

(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) COMPLETE DATE
S 830	Continued From page 6 should be complete. On 9/28/23 at 10:27 AM, in presence of another surveyor, the HRD confirmed that four of the ten employees did not have a background check prior to their date of hire. On 9/28/23 at 11:47 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that the employees did not have a background check prior to their date of hire. On 9/28/23 at 11:58 AM, in the presence of the survey team and LNHA, the DON stated that the employees should have had a background check prior to their date of hire. A review of the undated facility provided policy, titled "New Hire and Onboarding Process" included the following: Prior to a start date: Complete a background check. A review of the facility provided policy titled, "Prohibition of Resident Abuse & Neglect" dated 3/18/23, included the following: Employee and Volunteer Screening 4. Conduct background check as appropriate and review findings ... On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings.	S 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061204	A. BUILDING: _____ B. WING _____	C 09/28/2023

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S1405	Continued From page 7	S1405		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interviews and review of facility provided pertinent documentation, it was determined that the facility failed to ensure that four (4) of ten (10) newly hired employees (Staff #2, #5, #9, and #10) had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following:	S1405	Element One - Corrective Action: It is the practice of the Center to ensure that all employees have physical examinations completed before hire. All current employees were audited to ensure that physical examinations were completed. Element Two - Identification of at-Risk Residents: This standard was not met for Staff #2, #5, #9, and #10. All employees and residents can potentially be affected by this deficient	10/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061204	A. BUILDING: _____ B. WING _____	C 09/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1405	Continued From page 8 1. A review of the nine randomly selected newly hired employee files included the following: Staff #2, a Physical Therapy Assistant (PTA), hired 12/20/21, had an examination dated [Ex.Order 26.4(b)]. Staff #5, a Registered Nurse (RN) prior Director of Nursing, hired 8/23/21, did not have an examination in their file. Staff #9, a Certified Nursing Assistant (CNA), hired 3/26/23, had an examination dated [Ex.Order 26.4(b)(1)]. On 9/28/23 at 9:44 AM, the surveyor interviewed the Human Resource Director (HRD) regarding the process for physicals of newly hired employees. The HRD stated that the new employee will come in and get a physical done and a TB (tuberculin) test done. The surveyor asked when the HRD started at the facility. The HRD stated that she had started on 8/21/23. The surveyor asked the HRD if the employee files that were provided to the surveyor were the complete files. The HRD stated that she could not speak for someone else's work and that if the prior person went through her process that the files should be complete. On 9/28/23 at 10:27 AM, in presence of another surveyor, the HRD confirmed that three of the nine employees did not have the required physical examination. On 9/28/23 at 11:47 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that the employees did not have the required physicals. On 9/28/23 at 11:58 AM, in the presence of the	S1405	practice. Element Three - Systemic Change: All current employees were audited to ensure that physical examinations were completed. An Employee File Checklist was created for the Human Resources Director to utilize upon hire, and the Administrator/designee is to review all files before the hire date for three months and then to be re-evaluated depending on findings. Element Four - Quality Assurance: An Employee File Checklist was created for the Human Resources Director to utilize upon hire, and the Administrator/designee is to review two files before the hire date for three months and then to be re-evaluated depending on findings. This audit will serve as a second verification of all needed requirements for new staff members. The Human Resources Director/Designee will submit new hire folders to the Administrator/designee before the employee start date for verification of required documents. Results will be reported monthly to the QAPI team for review and revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 9 survey team and LNHA, the DON stated that the employees should have had the physicals. The LNHA acknowledged that the facility policy did not meet the state regulation. 2. On 9/21/23 at 10:08 AM, the surveyor reviewed one (1) employee file which revealed that Staff #10 was hired on 4/18/23 and the physical exam by the physician was done on [redacted]. On 9/21/23 at 12:01 PM, the surveyor in the presence of the survey team interviewed the HRD. The HRD informed the surveyor that she was a full-time employee at the facility and was responsible for recruiting, onboarding new hires, compliance, license verification, daily reporting for the state, payroll analysis, and accounts payable/receivables. The HRD stated that part of her responsibilities was the hiring process, and running background checks, "I make sure that they (new employees) have their hepatitis declination/acceptance, vaccination, and physical. I prefer they do physicals before they start, they get 30 days from the nurse, for the doctor's physical before they start." On that same date and time, the surveyor asked the HRD if the mentioned responsibilities and timeframe for new hire requirements were the facility practice and policy, the HRD responded, "To be honest it's learned." The surveyor showed the employee file of Staff #10 that the physical examination of the physician was done and signed on 8/22/23 and another History and physical was undated and not signed by the practitioner. The HRD stated that "it should not be like that, that's over five months after the aide started." The HRD further stated, "It should have been done before she started to make sure that she was cleared and not sick."	S1405		

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S1405	Continued From page 10 On 9/22/23 at 10:07 AM, the survey team met with the LNHA and the DON. The surveyor notified the facility management of the above findings. The LNHA stated that the physician's physical exam should be done within 30 days of the hire date and the RN assessment before the staff starts. A review of the undated facility provided policy, titled "New Hire and Onboarding Process" included the following: Prior to a start date: The new fire will need to provide a Physical and PPD within a year prior to hire and complete their employee health file with the Nursing Department. On 9/26/23 at 9:26 AM, the surveyor met with the LNHA and the DON in the presence of the survey team. The surveyor notified the facility management of the above findings regarding the provided New Hire and Onboarding Process policy that was provided to the surveyor. The surveyor asked what the facility follows with regard to the physical exam of the physician. Both the LNHA and the DON stated that they follow CDC (Centers for Disease and Control and Prevention) guidelines and that the DON further stated that the physical exam of the physician should be before or on the date of hire of the new employee. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services. The facility management did not provide additional information and did not refute findings.	S1405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	Continued From page 11	S1410		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Ex Order 26. 4B1 skin test with five Ex Order 26. 4B1 units of Ex Order 26. 4B1 derivative. The only exceptions shall be employees with documented negative two-step Ex Order 26. 4B1 skin test results Ex Order 26. 4B1 within the last year, employees with a documented positive Ex Order 26. 4B1 skin test result Ex Order 26. 4B1 , employees who have received appropriate medical treatment for Ex Order 26. 4B1 , or when medically contraindicated. Results of the Ex Order 26. 4B1 skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Ex Order 26. 4B1 skin test result is less than 10 millimeters of induration, the second step of the two-step Ex Order 26. 4B1 test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to perform a two-step Ex Order 26. 4B1 skin test Ex Order 26. 4B1 as required for new employees hired for Ex Order 26. 4B1 (TB) for infection and disease screening. This deficient practice was identified for six (6) of ten (10) employee files (Staff #2, #3, #5, #6, #7 and #8) reviewed.	S1410	Element One - Corrective Action: It is the practice of the Center to ensure that all employees have a step-two Ex Order 26. 4B1 skin test with five tuberculin units of Ex Order 26. 4B1 derivatives. The files of current employees were audited for compliance. The Infection Preventions was educated to	10/12/23

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S1410	Continued From page 12 This deficient practice was evidenced by the following: On 9/28/23 at 8:30 AM, the surveyor reviewed ten randomly selected new employee health files for TB screening which revealed the following: Staff #2, a Physical Therapy Assistant (PTA), hired Ex.Order 26.4(b)(1), received their first dose on Ex.Order 26.4(b)(1), and the results were read on the same day. The first dose results were negative. There was no evidence a second dose was administered. The date of the test and the date of the result reading were the same day and was not a few days apart. Staff #3, a Housekeeping Aide (HK), hired Ex.Order 26.4(b)(1) received their first dose on Ex.Order 26.4(b)(1), and the results were read on Ex.Order 26.4(b)(1). The first dose results were negative. There was no evidence a second dose was administered. Staff #5, a Registered Nurse (RN) prior Director of Nursing, hired Ex.Order 26.4(b)(1), received their first dose on Ex.Order 26.4(b)(1), and the results were read on Ex.Order 26.4(b)(1). The first dose results were negative. There was no evidence a second dose was administered. Staff #6, a Licensed Practical Nurse (LPN), hired Ex.Order 26.4(b)(1), received their first dose on Ex.Order 26.4(b)(1), and the results were read on Ex.Order 26.4(b)(1). The first dose results were negative. There was no evidence a second dose was administered. Staff #7, a Registered Nurse (RN), hired Ex.Order 26.4(b)(1) received their first dose on Ex.Order 26.4(b)(1) and the results were read on Ex.Order 26.4(b)(1)2. The first dose results were negative. There was no evidence a second dose was administered. The	S1410	ensure all employees that are eligible for a two step Ex Order 26. 4B1 skin test receive it. The Infection Preventionist is currently utilizing a new form requiring a second Ex Order 26. 4B1 skin test. Element Two - Identification of at-Risk Residents: This standard was not met for Staff #2, #3, #5, #6, #7 and #8. All employees who are eligible for a two-step Ex Order 26. 4B1 test and residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: The Infection Prevention/designee will conduct an audit monthly to ensure that all employees who meet the criteria for a two-step Ex Order 26. 4B1 test have it administered timely. Element Four - Quality Assurance: Results will be reported monthly to the QAPI team for review and revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1410	Continued From page 13 test was done two months prior to hire. Staff #8, a Certified Nursing Assistant (CNA), hired Ex.Order 26.4(b)(1) received their first dose on Ex.Order 26.4(b)(1), and the results were read on Ex.Order 26.4(b)(1). The first dose results were negative. There was no evidence a second dose was administered. On 9/28/23 at 9:44 AM, the surveyor interviewed the Human Resource Director (HRD) regarding the process for TB screening of newly hired employees. The HRD stated that the new employee will come in and get a physical done and a TB test done. The TB test result would be read two days later. She added that the TB test was a twostep process and that it was done two weeks apart. The surveyor asked when the HRD started at the facility. The HRD stated that she had started on Ex.Order 26.4(b)(1). The surveyor asked the HRD if the employee files that were provided to the surveyor were the complete files. The HRD stated that she could not speak for someone else's work and that if the prior person went through her process that the files should be complete. On 9/28/23 at 10:27 AM, in presence of another surveyor, the HRD confirmed that six of the nine employees did not have the required two-step TB test. On 9/28/23 at 11:47 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that the employees did not have a two-step TB test. On 9/28/23 at 11:58 AM, in the presence of the survey team and LNHA, the DON stated that the employees should have had a two-step TB test.	S1410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1410	Continued From page 14 The LNHA acknowledged that the facility policy did not meet the state regulation. A review of the undated facility provided policy, titled "New Hire and Onboarding Process" included the following: Prior to a start date: The new fire will need to provide a Physical and PPD within a year prior to hire and complete their employee health file with the Nursing Department. On 9/28/23 at 01:30 PM, the survey team met with the LNHA, DON, and Vice President of Clinical Services (VPoCS). The facility management did not provide additional information and did not refute findings.	S1410		

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
315384 Y1	A. Building B. Wing Y2	11/21/2023 Y3

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

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 F0557	Correction	ID Prefix F0584	Correction	ID Prefix F0585	Correction
Reg. # 483.10(e)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.10(j)(1)-(4)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023
ID Prefix F0607	Correction	ID Prefix F0609	Correction	ID Prefix F0657	Correction
Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023
ID Prefix F0658	Correction	ID Prefix F0661	Correction	ID Prefix F0676	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.24(a)(1)(b)(1)-(5)(i)-(iii)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023
ID Prefix F0684	Correction	ID Prefix F0689	Correction	ID Prefix F0698	Correction
Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(l)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023
ID Prefix F0725	Correction	ID Prefix F0732	Correction	ID Prefix F0806	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.60(d)(4)(5)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	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
315384 Y1	A. Building B. Wing Y2	11/21/2023 Y3

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

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 F0812	Correction	ID Prefix F0842	Correction	ID Prefix F0883	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023
ID Prefix F0944	Correction	ID Prefix F0949	Correction		
Reg. # 483.95(d)	Completed	Reg. # 483.95(i)	Completed		
LSC	10/12/2023	LSC	10/12/2023		

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/28/2023	☐ YES ☐ NO

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
315384 Y1	A. Building B. Wing Y2	11/21/2023 Y3

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

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 10/12/2023	ID Prefix F0585 Reg. # 483.10(j)(1)-(4) LSC	Correction Completed 10/12/2023	ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 10/12/2023
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	
9/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061204 Y1	A. Building B. Wing Y2	11/21/2023 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S0830	Correction	ID Prefix S1405	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-9.3(b)	Completed	Reg. # 8:39-19.5(a)	Completed
LSC	10/12/2023	LSC	10/12/2023	LSC	10/12/2023
ID Prefix S1410	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-19.5(b)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/12/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

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9/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315384	A. BUILDING **01** B. WING _____	**09/28/2023**

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ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18** **NEW BRUNSWICK, NJ 08901**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 9/27/23 and 9/28/23, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. 112 licensed bed currently at 91 Rose Mountain Care Center is a two story building that was built in 1990's It is composed of Type V protected construction. The facility is divided into 5-smoke zones. The facility has a 60 KW generator located outside the building. The generator is fueled by natural gas. The resident room floor plan has an East and West wing.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 211		10/12/23

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

Electronically Signed | 10/13/2023

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.

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K 211	Continued From page 1 Based on interviews and documentation review on 9/27/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for seven (7) of seven (7) fire doors documented on the provided facility floor plans and was evidenced by the following: At approximately 9:45 AM, the surveyor asked the MD to provide the annual testing requirements for fire door assemblies. The MD stated that currently the facility did not document the required annual testing of the fire door's in accordance with NFPA 80 and NFPA 105 Standard for Smoke Doors Assemblies and other Opening Protectives. The MD indicated a monthly fire door inspection was logged, but the annual inspection of the fire door components on the log were not specified as per NFPA 80 Standard for fire doors and other opening protectives. The Administrator was informed of the finding's at the Life Safety Code Exit Conference on 9/28/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	Element One: Corrective Action It is the practice of the Center to ensure that fire door inspections are completed annually. Fire door inspections were completed and documented by the maintenance staff. The Fire Door Inspection tool was initiated in accordance with S&C 17-38-LSC. Maintenance staff were immediately re-educated on how to perform fire door inspections and use the fire door inspection tool. Element Two - Identification of at-Risk Residents: All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: Fire Door inspections were added to the Life Safety Code documentation review spreadsheet completed Annually. Element Four - Quality Assurance: The Life Safety Code Review spreadsheet will be submitted to the Administrator monthly and to the QAPI Committee quarterly.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101	K 321		11/17/23

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K 321	Continued From page 2 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/27/23, in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5,	K 321	It is the practice of the center to ensure that fire-rated doors to hazardous areas are self closing, labeled and separated by smoke resisting partitions. This standard was not met in 1 out of 10 hazardous storage areas in the facility. 5 additional doors were observed to have illegible or no fire rating label.	

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K 321	Continued From page 3 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was identified in one (1) of 10 hazardous storage areas in the facility and was evidenced by the following: 1) At 11:38 AM, the surveyor, MD and ADMIN observed that Resident Room [redacted] was now being used to temporary store combustible material. The room was more than 50 square feet in size and contained combustible boxes, plastic bags filled with resident clothing, 8 cushioned chairs. The door to the room did not have an auto-closing device installed. At the time of the observation, the surveyor interviewed the MD who confirmed that hazardous storage areas must have a door with a self-closing device. 2) At 10:02 AM, the surveyor and MD observed in the laundry room that one (1) of two (2) doors did not have a fire rating label and one (1) of two (2) doors (door by the maintenance shop) had a fire rating label, but it was painted and the fire rating was not legible. 3) At 10:21 AM, the surveyor and MD observed the double doors to the kitchen were labeled, but the labels were painted and the fire rating was not legible. 4) At 10:25 AM, the surveyor and MD observed the storage room (East) was filled with combustible items, and the door did not have a fire rating label. 5) At 10:27 AM, the surveyor and MD observed	K 321	Element 1 – Corrective Actions A self-closing device was installed in storage Room [redacted]. A new fire rated door was purchased and installed for one door in the laundry room on 11/17/23. The second door in the laundry room by the maintenance shop with paint covering the fire rated label was cleaned and the paint removed so the fire rated label is legible. The fire rating for this door complies with regulations. A new fire rated door was installed on both doors to the kitchen on 11/17/23. A new fire rated door was installed for the storage room (East) on 11/17/23. A new fire rated door was installed on the housekeeping storage closet on 11/17/23 and properly latches into the frame. Element Two – Identification of at Risk Residents All Residents and staff have the potential to e affected by these practices. Element Three – Systemic Change The maintenance Director and Administrator inspected all facility doors to ensure they met the	

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K 321	Continued From page 4 the housekeeping storage room door, did not have a fire rating label and the door would not latch into its frame. The MD confirmed the above findings during the observations. The ADMIN was informed of the findings at the Life Safety Code Exit Conference on 9/28/23. NJAC 8:39-31.2(e)	K 321	fire rating as required by regulations. Re-education was provided to the maintenance staff to check all doors after painting to be sure fire rating labels were not painted over and are legible. The Administrator and maintenance director make monthly rounds and check all fire rated doors for function, self-closure devices and fire rated label as required. Element Four – Quality Assurance An audit of all doors will be conducted weekly times four weeks then monthly for three months by the Maintenance Director to ensure all hazardous areas have self-closing doors, labeled, and separated by smoke resisting partitions with findings reported to the Administrator monthly. The Maintenance Director will reported monthly findings in aggregate at the quarterly at QAPI meeting.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		10/12/23

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K 345	Continued From page 5 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 9/27/23, in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to ensure smoke detection sensitivity testing were completed of the facility smoke detectors in accordance with NFPA 72 (2010 edition) section 14.4.5.3.2. The deficient practice was identified for two (2) of two (2) semi annual inspection reports provided and was evidenced by the following: At 10:00 AM, the surveyor reviewed all related fire alarm documentation reports dated: 6/15/23 and 12/22/22, provided by the MD, from the fire alarm vendor to determine if the sensitivity test was performed. The reports provided did not indicate any information on the testing of the smoke detectors for sensitivity. An interview was conducted with the MD, during document review, he was not sure if the required sensitivity test for the facility smoke detectors were performed. The MD further stated he would contact the facility fire alarm vendor to see if the sensitivity test was performed, but at the LSC exit no further documentation was provided. The ADMIN was informed of the findings at the Life Safety Code Exit conference on 9/28/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345	Element One - Corrective Action: It is the facility's practice to ensure all farm alarm systems are tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA72, National Fire Alarm and Signaling Code. All smoke detectors are being tested. Element Two - Identification of at-Risk Residents: This standard was not met on two of two semi-annual inspection reports. All residents and employees can potentially be affected by this deficient practice. Element Three - Systemic Change: Sensitivity testing will be performed according to state regulations, and testing records will be readily available. A new fire alarm company was contracted to perform smoke sensitivity tests. Maintenance Director was educated on on smoke sensitivty regulations. Element Four - Quality Assurance: An audit will be conducted monthly and reported quarterly at QAPI by the Maintenance Director to ensure all smoke detectors are working and that the sensitivity testing was done and in compliance with State regulations.	

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K 363	Continued From page 6	K 363		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire	K 363		10/12/23

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K 363	Continued From page 7 protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/27/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place was identified in three (3) of 30 resident room (RR) doors observed and was evidenced by the following: During the building tour on 9/27/23 from 9:15 AM to 01:45 PM, the surveyor in the presence of the RPOD and MD toured the facility and observed the following compromised RR doors. RR [redacted] door was stuck into its frame. RR [redacted] door will not latch into its frame. RR [redacted] door did not fully close into its frame. At the time of observations, the surveyor interviewed the MD, who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code exit conference on 9/28/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	Element One- Corrective Action: The facility's practice is to ensure room doors close completely to properly confine fire and smoke products and properly defend occupants in place. All doors were repaired and adjusted properly. An audit was completed immediately on all doors throughout the facility, and repairs were made upon discovery. Element Two - Identification of at-Risk Residents: This standard was not met in rooms [redacted] and [redacted]. All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: Ensuring the room doors close completely to properly confine fire and smoke products and defend occupants in place properly was added to the Maintenance monthly checklist. Element Four - Quality Assurance: An audit will be conducted by the Maintenance director/Designee twice monthly x once, then monthly, then quarterly, moving forward. Results will be reported quarterly to QAPI.	

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K 911	Continued From page 8	K 911		
K 911 SS=E	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation on 9/27/23, in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. for one (1) of one (1) generators. This deficient practice was evidenced by the following: At 12:05 PM, the surveyor and MD reviewed all the facility's generator documentation. The facility currently has one (1) exterior 60 KW (kilowatt) natural gas generator. The MD and ADMIN could not produce a documented reliability letter from the natural gas provider. Reliability letters from the natural gas vendor regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement	K 911	Element One - Corrective Action: It is the practice of the facility to demonstrate reliability regarding fuel supply. The facility located the reliability letter. Element Two - Identification of at-Risk Residents: This standard was not met when no reliability letter was provided regarding the facility's natural gas generator. All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: Reliability letters will be located in the Administrators and Maintenance office for easy accessibility. Education was provided to the Maintenance Director and Administrator on where reliability letter is located. The reliablity letter included information that was needed. Element Four - Quality Assurance:	10/12/23

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ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18** **NEW BRUNSWICK, NJ 08901**

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K 911	Continued From page 9 regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The MD confirmed there was no reliability letter available from the natural gas provider for the 60 KW natural gas generator for the facility to present to the surveyor. No additional information was received. The ADMIN was informed of the findings at the Life Safety Code exit conference on 9/28/23. NJAC 8:39-31.2(e) NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4.	K 911	An audit will be conducted by the Maintenance Director/Designee twice monthly x once, then monthly, quarterly, moving forward to make sure that the reliability letter will be maintained in the Administrator/Maintenance Directors office.Results will be reported quarterly to QAPI.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL	K 920		10/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315384	A. BUILDING **01** B. WING _____	**09/28/2023**

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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K 920	Continued From page 10 standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/27/2023, in the presence of the Maintenance Director (MD) and Administrator (ADMIN), it was determined that the facility failed to prohibit the use of extension cords and power cords, beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard and was identified in one (1) of four (4) offices observed and was evidenced by the following: At 11:32 AM, the surveyor, MD and ADMIN observed in the ([redacted]) Nurse Office, that a white multi-outlet power strip was plugged into a black multi-outlet power strip, that was plugged into a three (3) to one (1) adaptor then to the duplex wall outlet. The two (2) power strips had a total of nine (9) electronic devices plugged into both devices. The findings were verified by the MD and ADMIN	K 920	Element One - Corrective Action: The facility's practice is to abide by the power and extension cord regulations. All power strips were removed from the West Nurse Office. All offices and rooms were immediately audited to ensure compliance. Element Two - Identification of at-Risk Residents: This standard was not met in 1 of 4 offices observed. All residents have the potential to be affected by this deficient practice. Element Three - Systemic Change: Staff was educated by the Maintenance Director on regulations regarding the use of power cords and extension cords. Element Four - Quality Assurance: An audit will be completed by the Maintenance Director/Designee weekly of two random rooms for one month, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315384	A. BUILDING **01** B. WING _____	**09/28/2023**

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K 920	Continued From page 11 at the time of the observations, where they stated and confirmed that high draw appliances (refrigerator) and daisy chaining multi-outlet power strips, cannot be used in the facility and can lead to overloaded circuits and fire risk. The Administrator was informed of the finding at the Life Safety Code Exit Conference on 9/28/2023. NJAC 8:39-31.2(e)	K 920	monthly moving forward. Findings will be reported to quartly QUAPI.	

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
315384 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/21/2023 Y3

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

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	10/12/2023	LSC K0321	11/17/2023	LSC K0345	10/12/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	10/12/2023	LSC K0911	10/12/2023	LSC K0920	10/12/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
9/28/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO