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 12/12/2024

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 000	INITIAL COMMENTS Complaint #:NJ 176597 Survey Date: 12/12/24 Census: 84 Sample: 18 + 2 Closed Records 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		12/25/24

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

Electronically Signed | 12/24/2024

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure a) meals were consistently provided in a dignified and homelike manner, and b) provide resident meal assistance in a dignified manner. The deficient practice was observed in the main dining room, for 2 of 2 residents (Resident #33 & #48) and on 2 of 2 units (East and West). The deficient practice was evidenced by the following: a) On 12/03/24 at 12:10 PM, Surveyor #1 observed the meal service in the main dining room. A staff member brought a tray over to Resident #33, who had just returned from the NJ Ex Order 26.4(b)(1). The staff did not offer Resident #33 hand hygiene upon re-entering from the NJ Ex Order 26.4(b)(1). The staff then proceeded to set up the resident's meal, without removing the food	F 550	Rose Mountain Care Center Facility ID 315384 Survey Date 12/12/24 F550 SS E ELEMENT ONE: CORRECTIVE ACTION All staff that pass out food trays were re-in serviced on 12/3/24-12/5/24 on hand hygiene for both residents and staff pre, post meal and when passing out trays. In addition, staff were re-in serviced on not leaving garbage including cup lids C.N.A. #2 was immediately re-in serviced and counseled on zero tolerance on phone use as per facility policy, and in employee handbook, educated upon hire, annually, and as evidenced by C.N.A. signature in employee handbook. In addition, c.n.a.#2 was re-in serviced on sitting level with resident while assisting	

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F 550	Continued From page 2 items from tray, then she dropped a peanut butter and jelly sandwich on the floor. The staff then proceeded to pick the sandwich up from the floor and placed the soiled sandwich in the tray lid that was face up, along with the other trash, which was directly in front of the resident meal tray. Surveyor #1 continued to observe the meal service and multiple staff continued to set the meal trays in front of six other residents, and placed the tray lid upright which was used as a garbage receptacle next to the resident's meal. The meal tray was also left on the table with the meal items on it. On 12/04/24 at 12:30 PM, Surveyor #1 observed the meal service in main dining room. The surveyor observed that staff were again, delivering meal trays and leaving the trays on the table in front of the residents, staff opened items and placed the garbage in front of the residents inside of the face up tray lid. On 12/11/24 at 10:16 AM, Surveyor #1, in the presence of the survey team, interviewed the U.S. FOIA (b)(6) regarding the meal service. Surveyor #1 asked if leaving the garbage at the table with the residents meal tray was dignified. The U.S. FOIA (b)(6) confirmed that it was not dignified and the U.S. FOIA stated there were carts in the dining room that should be used for the dirty items. b) 1. On 12/12/2024 at 8:11 AM, Surveyor #2 observed Resident #48 lying in bed and CNA #2 sitting in a chair next to the resident using her cell phone. Surveyor #2 observed the partially eaten breakfast meal on the overbed table. When Surveyor #2 entered the room, CNA #2 closed	F 550	with meals. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents that require hand hygiene prior to meals and require assistance with meals can be affected. All residents can be affected by staff personal cell phone use□ ELEMENT THREE: SYSTEMIC CHANGES: All staff that pass out food trays were re-in serviced on 12/3/24-12/5/24 on hand hygiene for both residents and staff pre, post meal and when passing out trays. All staff were re-inserviced on zero tolerance on personal use of cell phones. All staff that assist residents with eating were re-in serviced on sitting level with resident while assisting with meals. A visual audit of meal pass was completed daily x 5 days starting 12/5/2024 at various mealtimes to assess any staff members that may not be practicing proper hand washing with residents and when passing out trays, as well as when assisting residents to eat, staff is sitting. The Director of Nursing/Licensed Nursing Home Administrator completed daily facility rounds at different times to audit staff personal cell phone use. ELEMENT FOUR: QUALITY ASSURANCE: Food Service Director/Dietician/Designee will visually audit (and document) dining services at various times/meals to assess	

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F 550	Continued From page 3 her cell phone cover and continued to assist feeding Resident #48. Surveyor #2 observed the breakfast meal garbage of a drinking lid and plastic in the plate lid on the overbed table. A review of the medical record revealed that Resident #48 had been admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the quarterly MDS included but was not limited to; the staff was NJ Exec Order 26.4b1 a BIMS for Resident #48; and that Resident #48 was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 A review of the resident-centered on-going Care Plan included but was not limited to; focus areas of the potential to NJ Exec Order 26.4b1 [redacted] which include to assist with meals and to engage the resident in conversation to offer opportunity for reminiscing. On 12/12/2024 at 8:17 AM, CNA #2 stated that she should not have been using her cell phone, "I apologize" and further stated that she should have used hand hygiene after using her cell phone for infection control reasons. On 12/12/2024 at 12:44 PM, the above observation was discussed with the facility. The U.S. FOIA (b) acknowledged that was not allowed. 2. On 12/12/24 at 8:14 AM, Surveyor #1 observed Resident #15 in bed, and a staff was observed feeding the resident while standing to the side of the resident. On 12/12/24 at 8:27 AM, Surveyor #1 interviewed CNA #1 regarding if staff could assist a resident	F 550	staff compliance with resident and staff hand hygiene, and staff are sitting when assisting resident with meals, daily x 5days, weekly x4 and monthly x4. Needed corrections will be addressed as they are discovered. Findings to be reported to QAPI team for review and action as necessary. DATE OF COMPLIANCE:12/25/24	

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F 550	Continued From page 4 with the meal, while the staff was standing. CNA #1 stated that the staff had to be seated while assisting the residents for safety concerns. The facility Admission Agreement revealed: Every resident has a legal right to the following: Physical and Personal Environment: To live in a safe, clean, comfortable and home -like environment. To be treated with courtesy, dignity and respect.	F 550		
F 584 SS=D	NJAC 8:39-4.1(a); 27.1(a) 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;	F 584		12/25/24

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F 584	Continued From page 5 §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; §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: Based on observation, interview, and record review, it was determined that the facility failed to provide a homelike environment by administering medications to a resident who was in the dining room for the breakfast meal. This deficient practice was identified for 1 resident (Resident #83) during the meal observation and was evidenced by the following: On 12/06/2024 at 8:25 AM, the surveyor observed a Registered Nurse (RN) #1 approach Resident #83 sitting alone at a table in the main dining area preparing to eat breakfast which was on the table. RN #1 administered Resident #83 medications and exited the area. The surveyor observed there were multiple other residents throughout the main dining area as well. On 12/06/2024 at 8:30 AM, the surveyor inquired about administering medications in the dining	F 584	Rose Mountain Care Center Facility ID: 315384 Survey Completion date 12-12-2024 F584 SS-D Safe/Clean/Comfortable/Homelike Environment ELEMENT ONE: It is the practice of the Center to ensure that all residents reside in a safe, clean, homelike environment. The nurse (RN #1) that administered the medication in the dining room to resident #83 was immediately educated on ensuring medication is not administered in the dining room to maintain resident privacy. ELEMENT TWO: The standard was not met for resident #83. All residents who receive medication have the potential to be affected by this	

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F 584	Continued From page 6 area in front of other residents during breakfast. RN #1 stated Resident #83 was "already in the dining room" and that the resident needed to take the medications. The RN further stated the purpose of not administering medications in the dining area was because the resident could not always be supervised. RN #1 acknowledged Resident #83 was not care planned to have medications administered in the dining room and that, "it was my fault, sorry." On 12/06/2024 at 8:45 AM, the surveyor approached the RN as she was walking toward the medication cart. U.S. FOIA (b)(6) was in the hallway at the time of the observation and the surveyor informed the U.S. FOIA (b) of the observation, who stated, "Oh, that's not right". On 12/06/2024 at 8:47 AM, RN #1 stated that she administered NJ Exec Order 26.4b1 to Resident #83 and that those supplements were to be given with meals. A review of the medical record revealed that Resident #83 had been admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 A review of the most recent Admission Minimal Data Set (MDS) an assessment tool used to facilitate resident care, dated NJ Exec Order 26.4b1, included but was not limited to; a Brief Interview for Mental Status (BIMS) score of NJ Exec Order 26.4b1 indicating NJ Exec Order 26.4b1 A review of the Order Summary Report dated active orders as of NJ Exec Order 26.4b1 included but were not limited to; dated NJ Exec Order 26.4b1	F 584	deficient practice. ELEMENT THREE: All RN/LPN□s were educated on the facilities policy for medication administration, including not administering medication in the dining room. The nursing education was completed by 12/25/24. QUALITY ASSURANCE: To maintain and monitor ongoing compliance 3 nurses will be med passed monthly by the pharmacy consultant/DON/ADON. In addition, DON or their designee will conduct observation of the dining room weekly x 4 weeks, then monthly x 3 months, then quarterly. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary. Completion date: 12-25-2024	

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F 584	Continued From page 7 NJ Exec Order 26.4b1 [redacted]. The medications were not ordered to be given with meals. A review of the facility provided policy, "Medication Administration" undated, included but was not limited to; B. Medication administration may begin sixty minutes before the scheduled time but may not exceed sixty minutes after the scheduled time. 4. Medications ordered before meals approximately thirty minutes before meals. Medications ordered after meals are no later than thirty minutes after a meal has ended. The policy did not address administering medications in the dining room. On 12/12/2024 at 12:44 PM, the surveyor informed the facility administrative staff. The facility had no additional information to provide. NJAC 8:39-4.1(a)(12); 27.1	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide nail care to residents who were unable to carry out activities of daily living (ADLs). This deficient practice occurred for 2 of 2 residents (Resident	F 677	Rose Mountain Care Center Facility ID 315384 F677 SS D Element One - Corrective Action: Residents # 19 and #33 had NJ Exec Order 26.4b	12/25/24

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F 677	Continued From page 8 #19 and #33) reviewed for [redacted] and was evidenced by the following: 1. On 12/3/24 at 10:19 AM, during an initial tour, the surveyor observed Resident #19 sitting in their bed. The surveyor observed the resident's [redacted] On 12/4/24 at 9:14 AM, the surveyor observed the Resident #19 lying in their bed. Resident #19 had [redacted]. When asked by the surveyor, the resident stated staff did not [redacted]. The surveyor reviewed the medical records of Resident #19 which revealed: A review of the Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included, but were not limited to; [redacted]	F 677	completed on 12/12/24. Element Two -Identification of at Risk Residents: All residents that are dependent on their activities of daily living (ADL), are at risk. A facility wide audit was completed on all dependent residents to ascertain grooming including nails on 12/12/24 ELEMENT THREE: SYSTEMIC CHANGES: All clinical staff were re-educated on ensuring residents are groomed, including nail care on 12/12/24. QUALITY ASSURANCE To maintain and monitor ongoing compliance Unit Managers/designees will audit 3 dependent residents per day per unit daily x 5 days, weekly x 4 weeks and monthly x 4 months to ensure residents hygiene including nail care is completed. Needed corrections will be addressed as they are discovered. Findings to be reported to Quality Assurance Performance Improvement team for review and action as necessary. Date of Completion: 12/25/24	

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F 677	Continued From page 9 NJ Exec Order 26.4b1 . A review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4 revealed the Resident #19 had a Brief Interview for Mental Status (BIMS) of NJ Exec Order 26.4b1, indicating the resident's cognition was NJ Exec Order 26.4b1 Section NJ Ex O documented that Resident #33 had NJ Exec Order 26.4b1 A review of the Care Plan included a Focus area for an NJ Ex Order 26.4(b)(1) deficit related to NJ Ex Order , NJ Ex Order ... Goals included will receive NJ Ex Order 26.4(b)(1) necessary to meet NJ Ex Order 26.4(b)(1) through next review. Interventions included but were not limited to ...Assist with NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) as needed; NJ Ex Order 26.4(b)(1) - Assist X 1. On 12/12/24 at 8:20 AM, the surveyor observed the Resident #19 having breakfast in their bed. Resident #19 was holding a glass of juice in their left hand and the surveyor observed NJ Exec Order 26.4b1 . Resident #19 stated the staff did not NJ Exec Order 26.4b1 during care. 2. On 12/05/24 at 9:42 AM, the surveyor observed Resident #33 sitting in their wheelchair, the nails were NJ Exec Order 26.4b1 Resident #33 stated NJ Exec Order 26.4b1 " The resident looked at their NJ Ex Order 26.4(b)(1) and further stated they look NJ Exec Order 26.4b1." I NJ Ex Order 26.4(b)(1) in my sleep. I have NJ Exec Order 26.4b1 and I am not able to NJ Exec Order 26.4b1 on my own.	F 677		

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F 677	Continued From page 10 The surveyor reviewed the medical records of Resident #33 which revealed: A review of the Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the Resident #33 had a Brief Interview for Mental Status (BIMS) of [redacted] indicating the resident was NJ Exec Order 26.4b1. Section [redacted] documented that Resident #33 required NJ Ex Order 26.4(b)(1) with [redacted] A review of the individualized Care Plan included a Focus area for ADL (activities of daily living) deficit related to U.S. FOIA (b)(6). Goals included will be [redacted] dressed and well groomed daily to promote dignity and psychosocial well-bring through next review and will NJ Ex Order 26.4(b)(1) necessary to meet [redacted] through next review. Interventions included but were not limited to ... [redacted] with [redacted], [redacted] and [redacted] as needed. On 12/11/24 at 11:07 AM, during an interview with the surveyor, Certified Nurse Aide (CNA) #3 stated [redacted] was provided twice weekly. The process was that they must ask the nurse first if it was okay to provide [redacted].	F 677		

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F 677	Continued From page 11 On 12/11/24 at 11:09 AM, during an interview with the surveyor, CNA #4 stated the process was to check resident's [NJ Ex Order 26] prior to meals and during their care. The CNA further stated the staff must ask the nurse if the [NJ Ex Orde] needed to [NJ Ex Order 26] and [NJ Ex Orde] would be cleaned as needed. [NJ Ex Order 26.4(b)(1] was explained during training and orientation. On 12/11/24 at 11:32 AM, during an interview with the surveyor, the assigned CNA #1 stated nail care was provided during morning care. The CNA #1 further stated if the [NJ Ex Orde] needed to be [NJ Ex Order 26.4(b)(1] I would check with the nurse prior to providing the [NJ Ex Order 26.4(b)(]. The CNA #1 stated the [NJ Ex Order 26.4(b)(would be documented in the book but she could not provide the book. On 12/12/24 at 8:30 AM, the surveyor observed Resident #33 eating breakfast in the dining room, and observed the [NJ Exec Order 26.4b1]. The resident shook their head sideways indicating that their [NJ Exec Order 26.4b1]. On 12/12/24 at 8:33 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) #1 stated If I noticed the resident with [NJ Ex Order 26.4(b)(1)], I would ask the resident's CNA to trim resident's [NJ Exec Order 26.4b1] a resident if they have [NJ Exec Order 26.4b1]. The LPN further stated that [NJ Exec Order 26.4b1] were all part of the morning care and would be done as needed. The [U.S. FOIA] stated it was important to provide [NJ Ex Order 26.4(b)(for patient safety so they would not [NJ Ex Ord] themselves [NJ Exec Order 26.4b1]. On 12/12/24 at 8:57 AM, during an interview with	F 677		

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	315384	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 677	Continued From page 12	F 677		

the surveyor, the U.S. FOIA (b)(6) stated if the resident had NJ Exec Order 26.4b1, it was expected the staff would provide NJ Exec Order 26.4b and if the resident was NJ Exec Order 26.4b then they staff could NJ Ex resident's NJ Ex Order The NJ Exec Order 26.4b further stated the NJ Exec Order 26.4b was important because it was a part of hygiene, dignity, and resident might NJ Exec Order 26 themselves. The NJ Exec Order 26.4b observed Resident #19 and 33's nails in presence of the surveyor and acknowledged that the staff should have NJ Ex their NJ Ex Order

On 12/12/24 at 12:23 PM, the survey team met with the U.S. FOIA (b)(6) . The surveyor presented above mentioned concerns with the team.

A review of the facility provided, "Certified Nurse Aide Job Description" dated 2/2024, included but was not limited to; 3.) Provides personal care to residents/ guests (bathing, cleaning fingernails, shaving and perineal care, etc.) and assures that resident/guest dresses appropriately.

The surveyor reviewed the facility policy titled "Activities of Daily Living (ADL's) Policy" dated 12/23 included "Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Under Policy Interpretation and Implementation: 2.) Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, ...assistance with: a. hygiene (bathing, dressing, grooming, and oral care)."

On 12/12/24 at 03:01 PM, the survey team met with the U.S. FOIA (b)(6) for

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F 677	Continued From page 13 an exit conference. The facility management did not provide additional information and did not refute the findings.	F 677		
F 679 SS=F	NJAC 8:39-27.1(a), 27.2(g) Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to a.) carry out activities per a resident's care plan for 1 of 5 residents reviewed (Resident #25), and b.) conduct on-going activity assessments to determine resident's interests, hobbies, and cultural preferences to acquire a meaningful life for 5 of 5 residents (Resident #3, #21, #25, #83, #84) reviewed for activities. This deficient practice was evidenced by the following: 1. On 12/3/2024 at 9:58 AM, the surveyor observed Resident #25 lying in bed. Resident #25's family member was present and stated that the resident was supposed to be getting a daily newspaper in their NJ Ex Order 26.4(b)(1).	F 679	F679 1: The facility implemented a recreation attendance record for the 7 residents identified. All care plans for the 7 residents identified were updated appropriately. 2: All residents had the potential to be affected by the deficient practice so the facility implemented a recreation attendance record for all other residents as well. 3: The care plans for all current residents were reviewed and updated as needed. The Activities director and staff were	3/3/25

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F 679	Continued From page 14 On 12/5/2024 at 8:27 AM, the surveyor observed Resident #25 lying in bed and no newspaper was available. On 12/5/2024 at 9:35 AM, the surveyor observed Resident #25 lying in bed and no newspaper available. On 12/5/2024 at 9:49 AM, the U.S. FOIA (b)(6) was interviewed. The stated that she had been for only a few weeks. The stated that when a resident was admitted, the activities department would conduct an assessment. She stated the assessment would go into the electronic medical record (EMR) to track residents participation in activities. The stated she was familiar with Resident #25 and that the resident was supposed to get a newspaper daily, but she was not sure who was supposed to provide the newspaper. The stated that there should be an activities assessment done quarterly for all residents. On 12/5/2024 at 9:50 AM, the U.S. FOIA (b) (6) approached the surveyor and the AD. The U.S. FOIA (b)(6) stated that the newspaper had been a discussion in morning meeting "very far back but not sure of the date" and that the surveyor should ask the admissions staff about the newspaper. On 12/5/2024 at 9:57 AM, the Admissions staff who stated she was not sure why the resident did not get a newspaper and that she would investigate. A review of the Admission Record (AR) revealed Resident #25 had been admitted with diagnoses	F 679	educated on proper care planning of activity preferences as well as the recreation attendance record policy / process. 4: The Administrator / designee will audit 5 care plans weekly x4 to ensure they reflect activity preferences that were identified in the assessment. The administrator / designee will also audit 10 resident attendance records weekly x4 then monthly x2 ensuring proper compliance, results will be reported to the QAPI committee for review and action as necessary 5: 3-3-2025	

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F 679	Continued From page 15 which included but were not limited to; [redacted]. A review of the most recent facility provided, "Activity Participation Review" was dated [redacted], and included but was not limited to; B. Attendance and Participation Summary ... relaxing in room reading the newspaper and conversation with staff. On 12/05/2024 at 10:12 AM, the [redacted] stated that she had "no idea" who went to Resident #25's [redacted] and was not aware of any documentation of Resident #25's participation in activities. On 12/05/2024 at 11:13 AM, the in presence of the survey team, the [redacted] and the [redacted] were interviewed. The [redacted] stated an activities staff member who worked at a different facility was helping with the facility's activities program. The [redacted] stated there was no documentation that the residents had participated in any activities that were identified as their individual interests. The [redacted] further stated the previous [redacted] left the facility in the summer. 2. On 12/05/2024 at 1:38 PM, the surveyor requested the activity assessments and participation documentation for Resident #3, #21, #25, #83, and #84.	F 679		

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On 12/05/2024 at 2:50 PM, the U.S. FOIA (b) (6) informed the survey team that there was no updated activity assessments for the residents.

A review of the EMR's revealed the following:

Resident #3, admitted in NJ Exec Orde, and the last documented activity assessment was dated NJ Ex Order 2 and there were no activity participation logs to confirm that resident participated in activities.

Resident #21, admitted in NJ Exec Order 2 and there were no activity assessments or documentation to confirm activity participation.

Resident #25, admitted NJ Exec Orde and the last activity assessment completed was dated NJ Exec Orde and there was no documentation to confirm activity participation.

Resident #83, admitted NJ Exec Ord. On 12/05/2024, the surveyor was told there was no activity assessment completed and documented. On 12/11/2024 at 1:54 PM, the facility provided a handwritten form of three pages that had not been entered into the EMR. Page one had the resident's name and was filled out, pages 2 and 3 had no resident name, admission date, room number, or date of birth and page 3 was blank.

Resident #84, admitted NJ Exec Orde, and there were no activity assessments completed and no documentation to confirm activity participation.

The facility was unable to provide any documentation to confirm resident's participation activities for the residents who resided in the

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F 679	Continued From page 17 facility. The surveyor requested a policy for activities and received the facility provided job description for Recreation Director. The description included but was not limited to; summary: establish, coordinate, and direct a comprehensive recreation program ... develops a program to relate to the physical, psychological, social, intellectual, cultural, and spiritual needs of each resident. Establish, coordinates, and documents all assessments, review plans and progress notes pertaining to activities. Facilitate activity and recreation pursuits of residents. Part I: Standards: 1. Coordinate, monitor, and document all assessments timely and appropriately. 3. Review progress notes ... for tardiness and accuracy of treatment outcomes. 4. Design and implement a comprehensive therapeutic program of activities accommodating resident needs, abilities, and interests. 5. Adheres to objectives, standards of practice, policies and procedures ... for the therapeutic recreation department and ensures personal are being supervised. Part II: 13. Evaluates and recommends appropriate activities programs for the residents. On 12/12/2024 at 12:44 PM, the above concerns were discussed with the facility administration. The facility had no additional information to offer. NJAC 8:39-4.1 (a)(24); 7.1(a); 7.2; 7.3(a)(1-7)(g); 8.1	F 679		
F 680 SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a	F 680		3/3/25

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F 680	Continued From page 18 qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. 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 facility activities program was directed by a qualified therapeutic recreation specialist or activity professional. The deficient practice had the potential to affect all residents who resided in the facility and was evidenced by the following: On 12/03/2024 at 9:58 AM, Surveyor #1 observed a family member in resident #25's room. The family member stated they were upset because Resident #25 was supposed to be getting a daily newspaper in NJ Ex Order 26.4(b)(1), but no newspapers were being delivered. On 12/04/24 at 9:19 AM, Surveyor #2 observed a staff assisting residents at mealtime in the main dining room. The staff identified herself as the U.S. FOIA (b) (6) / U.S. FOIA (b) (6)	F 680	F680 1: The facility was successful in hiring a full time certified U.S. FOIA (b) (6) with a start date of NJ Exec Order 26.4b1 2: All residents had the potential to be affected by the deficient practice 3: The non certified U.S. FOIA (b) (6) who is now an U.S. FOIA (b) (6) and the other activity staff were made aware of the hiring and were also educated that the certified AD will be responsible for completing the assessments. 4: The Administrator / designee will audit the new directors performance in general and specifically with completing the assessments accurately and timely.	

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F 680	Continued From page 19 (U.S. FOIA (b) (6)). On 12/05/2024 at 9:49 AM, Surveyor #1 observed activities taking place in the main dining area. Surveyor #1 interviewed a staff member who introduced herself as the U.S. FOIA (b)(6) The U.S. FO stated she had been the U.S. FOIA for two weeks and prior to that, she had been with the facility as a NJ Exec Order 26.4b1. When asked what the process was for residents, the NJ Exec stated upon admission there would be an activities admission assessment completed and that would go into the electronic medical record (EMR). The NJ Exec D stated after that, each resident would have quarterly activity assessments. Surveyor #1 inquired about Resident #25's daily newspaper and the U.S. FO replied she was familiar with the resident but was not sure who was responsible to deliver the newspaper. At 10:12 AM, Surveyor #1 asked the process of documentation to determine which residents were at which activities or offered any activities or room visits. The U.S. FO replied she had no idea who conducted resident room visits or documentation of resident activity participation. On 12/05/24 at 11:17 AM, the U.S. FOIA (b)(6) (who introduced herself to Surveyor #1 as the AD) and U.S. FOIA (b) (6) addressed the survey team regarding the U.S. FOIA (b)(6) and stated another facility U.S. FOIA (b)(6) would help at times, but that there was no trained NJ Exec Order 26.4b1 currently at the facility since the summertime when the last U.S. FO left the position. The U.S. FOIA (b)(6) stated she will now be the U.S. FOIA (b)(6). The U.S. FOIA (b)(6) stated that there has not been a consistent activity U.S. FOIA (b)(6) since July, other people for a week or so. The surveyor asked if the U.S. FOIA (b)(6) had a Bachelor's degree and she stated the facility told her she would take an	F 680	Results will be reported to the QAPI committee for review and action as necessary 5: 3-3-2025	

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F 680	Continued From page 20 online course. The surveyor asked if she has ever been to a U.S. FOIA (b)(6) meeting or a resident care plan meeting and she stated, "I have not been to one yet". On 12/5/2024 at 9:08 AM, Surveyor #1 requested the activity policy and the NJ Ex job description. On 12/5/2024 at 10:34 AM, Surveyor #1 was provided only the signed NJ Ex job description. A review of the facility provided, "NJ Ex Order 26.4(b)(1) " job description date of hire NJ Ex Order 26.4(b)(1) included but was not limited to; Qualifications: Bachelor's degree from an accredited college .. with a major area in Recreations, Creative Arts, Therapy, Therapeutic Recreation, Art Education, Psychology, or Music Therapy. A Master's degree preferred. 2-3 years of experience in recreation and/or management experience. NJAC 8:39-8.2	F 680		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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, interview, and document review, it was determined that the facility failed to a) ensure a NJ Ex Order 26.4(b)(1) resident was provided with adequate NJ Ex Order 26.4(b)(1) to prevent	F 689	Rose Mountain Care Center Facility ID 315384	12/25/24

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F 689	Continued From page 21 NJ Ex Order 26.4(b)(1) and reassess, reevaluate, and implement appropriate NJ Ex interventions to the Care Plan (CP) for a resident who was at high risk NJ Exec Order 26.4b1. This deficient practice occurred for 1 of 2 residents reviewed for NJ Ex Ord (Resident #39), and b) ensure the facility, developed and implemented a consistent NJ Ex Order 26.4(b)(process to prevent potential NJ Ex Order 2 or NJ Ex Ord The deficient practice was identified for 5 of 5 residents (#11, #33, #54, #63 and #388) reviewed for NJ Ex Order 26.4(b)(and was evidenced by the following: a) On 12/04/24 at 9:30 AM, Surveyor #1 observed Resident #39 seated at a table by themselves in the main dining room, was drinking a beverage, and was observed wearing slippers on their feet and NJ Exec Order 26.4b1 were observed on the wheelchair. On 12/04/24 at 11:14 AM, Surveyor #1 interviewed the U.S. FOIA (b)(6)). The U.S. FOIA (b)(6) stated the facility conducted fall committee meeting twice monthly to review NJ Exec Ord and interventions to prevent falls and see what can be done differently to prevent falls. Th U.S. FOIA (b)(6) stated that the Department Heads including the U.S. FOIA (b)(6) and therapy attended. The U.S. FOIA (b)(6) also provided Resident #39's therapy treatment notes. A NJ Ex Order 26.4(b)(U.S. FOIA (b)(6)) Evaluation revealed: referred to U.S. FOIA due to new onset of NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) placing patient at risk for NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Orde further	F 689	Survey Completion Date □ 12/12/24 F689 SS - E (Free of Accident Hazards/Supervision/Devices) Element One: 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 NJ Ex Order 26.4(b)(1) in the last month to ensure an intervention was in place and on the care plan. Education provided to staff to ensure a thorough investigation is conducted when a fall occurs. It is the practice of the facility to implement a smoking process to ensure the safety of residents to prevent injury or fire. Education provided immediately for the residents and staff on the smoking policy and process. Element Two: This standard was not met for Resident #39, #11, #33, #54, #63, and #388. All residents who have had an accident and/or smoke have the potential to be affected by this deficient practice. Element Three: The Administrator/Designee, DON/Designee, and Unit	

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F 689	Continued From page 22 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1. Precautions: NJ Exec Orde On 12/04/24 at 4:18 PM, the surveyor reviewed the medical record for Resident #39 which revealed: The Admission Record (admission summary) revealed diagnoses, which included but were not limited to; NJ Exec Order 26.4b1 . The NJ Ex Or Risk Assessment, "Full Assessment" was completed on NJ Ex Order 26.4(b)(which indicated that the resident was a "NJ Ex Order 26.4(b)(1)" with a score of NJ Ex O An annual Minimum Data Set (an assessment tool) dated NJ Ex Order 26.4(b)(, which revealed the Brief Interview for Mental Status score was NJ Exec Order 26.4b1 which indicated Resident #39 had a U.S. FOIA (b)(6) . Section NJ Ex Orde NJ Ex Order 26.4(b)(1) revealed the resident required NJ Ex Order 26.4(b)(to NJ Ex Order 26.4(b)(1) and to go from NJ Ex Order 26.4(b)(1), and the resident required NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) . Resident #39 was coded "yes" for having NJ Ex Order 26.4(b)(1) that resulted in NJ Ex Order 26.4(b)(1) = NJ Exec Order 26.4b1). A Care Plan (CP) Focus: At risk for NJ Exec Orde due to NJ Ex Order 26.4(b)(1), which included resolved and current interventions had a Goal: Minimize the risk for NJ Ex Orde through next review, Date Initiated: NJ Exec Order 26.4b revealed the date of NJ Exec Order 26.4b1	F 689	Managers/Designee met to review the incident and accident report procedure. All incident and accident reports will be reviewed with the Interdisciplinary team 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. In addition, 6 residents with a PMH of multiple falls and poor cognition have been identified as a focus group to help decrease falls and injury with specialized diversional activities and groups. The Administrator met with residents and staff regarding the smoking process and implementation of a smoking binder. The residents were explained the importance of smoking safety and following the rules. They were educated about not holding their cigarettes and lighters as well as the designated smoking times. The residents were also educated on the facility's safety procedures regarding smoking. Element Four: An audit of two charts will be conducted weekly by the DON/Designee for three months to ensure residents with fall(s) have appropriate interventions in place and interventions are on the care plan. Results are to be reported to the QAPI team for review. The Administrator/Designee will complete observation of the smoking process monthly x 3 to ensure compliance.	

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	315384	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 689	Continued From page 23 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The Progress notes revealed the following: Effective Date, NJ Ex Order 26.4(b)(1) 18:54 (6:54 PM) revealed Resident #39 in dayroom eating dinner when NJ Ex Order 26.4(b)(1). Staff attended. NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 noted and resident send to hospital for evaluation. A Late Entry Progress Note by the Nurse Practitioner (NP), Effective Date NJ Exec Order 26.4b1 and signed by the U.S. FOIA on NJ Exec Order 26.4b1. The Chief Complaint: Status post Emergency Room visit after NJ Exec Order 26.4b1". Nursing reported resident NJ Ex Order 26.4(b)(1) in dining room from wheelchair." A Late Entry Physician (MD) Progress note, Encounter Date; NJ Ex Order 26.4(b)(1), Effective NJ Exec Order 26.4b1 revealed "Given the history of NJ Exec Order 26.4b1, continue with NJ Ex Order 26.4 prevention strategies including regular NJ Ex Order 26.4(b)(1) sessions to improve NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) use of NJ Ex Order 26.4(b)(1), ensuring that living area is well-lit and free of NJ Ex Order 26.4(b)(1), and use of assistive devices as needed for NJ Ex Order 26.4(b)(1). A Progress Note dated NJ Ex Order 26.4(b)(1) at 8:29 AM and signed by an U.S. FOIA revealed. Roommate called nurse attention to resident Resident was observed NJ Ex Order 26.4(b)(1) close to the lamp and stand table. Resident stated NJ Ex Order 26.4(b)(1) to dress. below the observed. A Progress Note Effective NJ Ex Order 26.4(b)(1) at 13:22 (1:22	F 689	Date of compliance 12/25/2024	

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PM) and signed by unidentified staff, revealed, Resident NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 .

A Progress Note Effective NJ Ex Order 26.4(b)(at 10:22 AM and signed by unidentified staff, revealed resident observed NJ Ex Order 26.4(b)(1) at bedside. Resident noted with NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) to bed, NJ Ex Order 26.4(provided.

A Progress Note Effective NJ Ex Order 26.4(b)(at 22:41 (10:41 PM) and signed by unidentified staff revealed "Resident observed NJ Ex Order 26.4(b)(1) by the door. Resident noted with NJ Ex Order 26.4(b)(to NJ Ex Order 26.4(. Stated" I was trying to NJ Ex Order 26.4(b)(1) ."

A Progress Note Effective NJ Ex Order 26.4(b)(at 16:24 (4:24 PM) signed by an LPN revealed Resident was found NJ Ex Order 26.4(b)(1) of room close to wheelchair. NJ Ex Order 26.4(b)(1) noted to NJ Ex Order 26.4(b)(1)

A Progress Note Effective NJ Ex Order 26.4(b)(at 22:58 (10:58 PM), signed by an LPN revealed "responded to NJ Ex Order 26.4(b)(from nurse's station, resident noted NJ Ex Order 26.4(b)(1) ... resident noted NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) ."

A Progress Note Effective NJ Ex Order 26.4(b)(at 23:57 (11:57 PM) and signed by an LPN revealed at 11:10 PM staff reported resident is NJ Ex Order 26.4(b)(1) , upon arrival resident noted NJ Ex Order 26.4(b)(1) by the door, bed was low, call bell NJ Ex Order 26.4(b)(1) , but not used, NJ Ex Order 26.4(b)(1) noted.

On 12/05/24 at 8:00 AM, the surveyor requested

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all fall investigations from the U.S. FOIA (b) (6)) for Resident #39.

On 12/05/24 at 9:06 AM, the U.S. FOIA (b) (6) provided the surveyor with the following NJ Ex Order 26.4(b)(1) incident reports and confirmed that what was provided was "everything".

The incident reports revealed:

NJ Ex Order 26.4(b)(1) - Date: NJ Ex Order 26.4(b)(1) - Nursing Description: notified by staff that resident NJ Ex Order 26.4(b)(1) [wheelchair] bedside and "Resident unable to give description". NJ Ex Order 26.4(b)(1) observed at time of incident: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) Under Notes: The team met to discuss residents NJ Ex Order 26.4(b)(1) in room. Sent to emergency room for evaluation and admitted with NJ Ex Order 26.4(b)(1)] and NJ Ex Order 26.4(b)(1).

A review of the CP revealed the following interventions initiated on NJ Ex Order 26.4(b)(1): Administer medications per physician order; Encourage to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1); Provide assistance to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) as needed; and Report development of NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) change in NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) status per facility guidance. Under focus: Readmit NJ Ex Order 26.4(b)(1) CP updated and the Interventions listed did not include any interventions added or revised NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) that occurred on NJ Ex Order 26.4(b)(1)

NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)-Nursing Description: Rounds after dinner NJ Ex Order 26.4(b)(1). Intervention added to CP on NJ Ex Order 26.4(b)(1), staff will offer resident the opportunity to NJ Ex Order 26.4(b)(1) after dinner.

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NJ Ex Order 26.4(b)(1) - Nursing Description: Resident in dayroom eating dinner when NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) noted, NJ Ex Order 26.4(b)(1) and physician ordered to be sent to Emergency Room. Under Notes: The tam met to review NJ Ex Order 26.4 on NJ Ex Order 26.4(b)(1) and staff observed the resident NJ Ex Order 26.4(b)(1). The intervention added to the CP on NJ Ex Order 26.4(b)(was Staff to ensure NJ Ex Order 26.4(b)(in place. There were no interventions to address who was supervising the resident during meals when the resident was NJ Ex Order 26.4(b)(1) .

NJ Ex Order 26.4(b)(1) - Resident attempted to NJ Ex Order 26.4 at 1:30 AM and get dressed and the CP intervention added NJ Ex Order 26.4(b)(, was to provide a digital clock.

NJ Ex Order 26.4 - NJ Ex Order 26.4(b)(- Nursing Description: Resident attempted to NJ Ex Order 26.4(b)(1) and NJ Ex with NJ Ex Order 26.4(b)(1) . The intervention added to the CP on NJ Ex Order 26.4(b)(1) was resident educated to ask for NJ Ex Order 26.4(b)(1) and not to NJ Ex Order 26.4(b)(1) when NJ Ex Order 26.4(b)(1). There were no interventions/revised interventions related to supervision at activities and were NJ Ex Or in place and if not effective revised.

NJ Ex Order 26.4(b)(1) - Nursing Description: Resident observed NJ Ex Order 26.4(b)(1) at bedside, noted with NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) Intervention added NJ Ex Order 26.4(b)(- Resident to ask for NJ Ex Order 26.4(b)(1) prior to attempting to NJ Ex Order 26.4(b)(1) when wants to NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1) Nursing Description: Resident observed NJ Ex Order 26.4(b)(1) by the door. Noted with NJ Ex Order 26.4(b)(to NJ Ex Order 26.4(b)(1). Resident

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stated: "I was trying to NJ Ex Order 26.4(b)(1)". On NJ Ex Order 26.4(b)(an intervention for NJ Ex Order 26.4(b)(1) was added to the CP. The CP did not address the previous intervention added on NJ Ex Order 26.4(b)(1) when the resident was also found with NJ Ex Order 26.4(b)(1) on NJ Ex O in the room trying to NJ Ex Order 26.4(b)(1).

NJ Ex Order 26.4(NJ Ex Order 26.4(b)(1 - Nursing Description: Resident found NJ Ex Order 26.4(b)(1) in room close to wheelchair and stated wanted to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) noted on NJ Ex Order 26.4(b)(1). On NJ Ex Order 26.4(b)(1 the team met to discuss NJ Ex Order 26.4 when resident was attempting to NJ Ex Order 26.4(b)(1) when noted NJ Ex Order 26.4(by staff. The intervention added to the CP on NJ Ex Order 26.4(b)(1) was to provide a NJ Ex Order 26.4(b)(The interventions that were added for the prior NJ Ex O were not modified/ addressed in the CP.

NJ Ex Order 26.4(NJ Ex Order 26.4(- Nursing Description: Resident was found NJ Ex Order 26.4(b)(1) in room next to bed and stated, "I was trying to NJ Ex Order 26.4(b)(1). I was NJ Ex Order 2 On NJ Ex Order 26.4(b)(- the team met to discuss NJ Ex O after a failed attempt to NJ Ex Order 26.4(b)(1). The intervention added to the CP was to offer NJ Ex Order 2 in the afternoon. The previous interventions that were added to prevent NJ Ex Orc in the room were not addressed or revised.

NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) Nursing Description: Resident NJ Ex Order 26.4(b)(1) by door and resident stated, " NJ Ex Order 2 " and sustained NJ Ex Order 26.4(b)(1). The CP intervention added NJ Ex Order 26.4(b)(1) was to provide a NJ Ex Order 26.4(b)(

NJ Ex Order 26.4(b - NJ Ex Order 26.4(b)(- Nursing Description: Staff responded to NJ Ex Order 26.4(b) at the nurse's station and found resident NJ Ex Order 26.4(b)(1). Resident stated was NJ Ex Order 26.4(b)(1) and NJ Ex O On NJ Ex Order 26.4(b)(the team met and determined that the resident

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wanted to [NJ Ex Order 26.4(b)(1)] before dinner, staff intercepted and placed in front of nursing station, and resident tried to [NJ Ex Order 26.4(b)(1)] and [NJ Ex O] The CP intervention was to encourage resident to participate in activities added [NJ Ex Order 26.4(b)(1)]. The previous interventions were not addressed or revised.

On 12/05/24 at 12:55 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] regarding the provided incident reports. The incident report for the [NJ Ex Or] [redacted] that occurred on [NJ Ex Order 26.4(b)(1)] did not have attached statement and asked the [U.S. FOIA (b) (6)] if there should have been statements with the incident report. The [U.S. FOIA (b) (6)] stated, "yes", when asked how [NJ Ex Order 26.4] happened, the [U.S. FOIA (b) (6)] stated, "I cannot tell you". The surveyor asked the [U.S. FOIA (b) (6)] if the facility knew the causal factor of [NJ Ex Order 26.4] and she stated, "this one they don't", and the surveyor asked the [U.S. FOIA (b) (6)] if a NJ Ex Order 26.4(b)(1) and she stated, "yes." The surveyor asked the [U.S. FOIA (b) (6)] if there was a root cause analysis and she stated, "no." The surveyor asked if the [NJ Ex Order 26.4(b)(1)] incident was a complete investigation to determine how the resident was NJ Ex Order 26.4(b)(1) and the [U.S. FOIA (b) (6)] stated, "no". The surveyor then reviewed the [NJ Ex Order 26.4(b)(1)] incident with the [U.S. FOIA (b) (6)] There was one statement from a nurse regarding finding resident [NJ Ex Order 26.4(b)(1)] and the surveyor asked the [U.S. FOIA (b) (6)] if the investigation was complete, and she stated, "no." The surveyor then reviewed the [NJ Ex Order 26.4(b)(1)] incident with the [U.S. FOIA (b) (6)] and the surveyor asked what the intervention was that was added to the CP and the [U.S. FOIA (b) (6)] stated 'NJ Ex Order 26.4(b)(1)". The surveyor asked was that an intervention based off of the root cause of [NJ Ex Order 26.] and the [U.S. FOIA (b) (6)] stated, "no, it is basic." The surveyor then reviewed the [NJ Ex Order 26.4(b)(1)], that again occurred in the resident's room. The surveyor asked the

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F 689	Continued From page 29 U.S. FOIA (b) (what the intervention was and she stated, the NJ Ex Order 26.4(. The surveyor asked was the root cause of NJ Ex Order 26.4 identified and a specific intervention added and the U.S. FOIA (b) (stated, "no". The U.S. FOIA (b) (stated we recognized that the old management team was not effective. On NJ Ex Order 26.4(at 8:27 AM, the Certified Nurse Aide (CNA #1) who was assigned to Resident #39 was interviewed after the CNA provided morning care to the resident and transported the resident to the dining room. The surveyor asked if the resident had NJ Ex Ord and the CNA stated, "yes" the resident had NJ Ex Ord and tried to NJ Ex Order 26.4(b)(1) to bed, and also did not like to NJ Ex Order 26.4(b)(1) . The CNA then stated, "we are supposed to NJ Ex Order 26.4(b)(1) on [him/her]". The Falls and Fall Risk Management Policy (undated) revealed: Policy Statement: Based on previous evaluations and current data, staff will identify interventions related to the resident's specific fall risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Procedure: 1. The interdisciplinary team, with the input of the Attending Physician as appropriate, will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). 4. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. Monitoring Subsequent Falls and Fall risk: 1. The staff will monitor and periodically document each resident's response to interventions intended to	F 689		

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reduce falls or the risks of falling. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed the Attending Physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors that continue to present a risk for falling or injury due to falls.

b. On 12/03/24 at 8:50 AM, the U.S. FOIA (b)(6) informed the survey team that the facility had residents who NJ Exec Order 26.4b and the survey team requested a list of residents who NJ Exec Order 26.4b NJ Ex Order 26.4(b)(times and the NJ Ex Order 26.4(b)(policy.

On 12/03/24 at 9:34 AM, the U.S. FOIA (b)(6), in the presence of another surveyor provided the NJ Exec Order 26.4b1 Hours, the NJ Exec Order 26.4b1 List list with resident names and the NJ Exec Order 26.4b1 Rules and Agreement. The surveyor asked for the NJ Exec Order 26.4b policy and the U.S. FOIA (b)(6 stated the 'NJ Exec Order 26.4b1 Rules and Agreement" was what the facility used and there was no different policy. The U.S. FOIA (b)(6 stated the document was filled out for every resident who NJ Exec Order 26.4b and a copy was in the Electronic Medical Record (EMR).

The NJ Ex Order 26.4(b)(1 Rules and Agreement revealed 1. Prior to being permitted to NJ Ex Order 26.4(a safe NJ Ex Order 26.4(b)(evaluation will be conducted by the nurse or designated member of the healthcare team. a. This evaluation will determine your ability to NJ Exec Order 26 independently, how much NJ Ex Order 26.4(b)(1) you will need, and whether any protective devices (such as a NJ Exec Order 26.4b1) may be used in order for you to be granted NJ Ex Order 26.4(b)(privileges. B. Your

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ability to [NJ Exec Order 26] and level of independence will be re-evaluated regularly and will be part of our plan of care. We will review your plan of care with you regularly and document the review in the medical record. 2. If it is determined you can safely [NJ Exec Order 26] independently, you may only [NJ Exec Order 26] in the designated [NJ Ex Order 26.4(b)(] area. You may never [NJ Ex Order 26.4] in your room or any other non designated [NJ Ex Order 26.4(b)(1)]. 3. You may never give [U.S. FOIA (b)(6)] matches to other residents or otherwise assist other patient or resident of the center to smoke. 4. For the safety of all staff and residents you may not retain your own [NJ Exec Order 26.4b1] or other course of ignition. If you have been evaluated as an independent [NJ Exec Order 26.4], you will be given your [NJ Exec Order 26] materials before going out to [NJ Ex Order 26.4(] and you must return them to the nurse when you return from [NJ Exec Order 26.4b].

On 12/04/24 at 9:39 AM, Surveyor #1 observed resident #388 [NJ Exec Order 26.4b1] in the courtyard.

On 12/04/24 at 9:40 AM, Surveyor #1 interviewed Licensed Practical Nurse (LPN #1) regarding the [NJ Exec Order 26.4b1] for Resident #388. She stated that she did not have any [NJ Exec Order 26.4b1] for any of the residents who [NJ Exec Order 26.4] that were on her assignment, and that maybe the [U.S. FOIA (b) (6)]) held the [NJ Exec Order 26.4b1].

On 12/04/24 at 9:44 AM, Surveyor #1 interviewed the [U.S. FO] who stated that the nurses held the [NJ Exec Order 26.4b1] and she did not hold them. Surveyor #1 asked where the [NJ Exec Order 26] were kept and she stated, it depends and she confirmed that she did not have any [NJ Exec Order 26.4] either.

On 12/04/24 at 9:50 AM, Surveyor #1 interviewed

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	315384	A. BUILDING _____ B. WING _____	C 12/12/2024

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 32 CNA #3 about the NJ Exec Order 26.4b process and she stated, "I don't know the process" and stated the NJ Exec Order 26.4b1 are with the nurse. On 12/04/24 at 10:00 AM, Surveyor #1 interviewed Resident #11 who stated they just started NJ Exec Order 26.4b again. On 12/04/24 at 10:20 AM, Surveyor #1 reviewed the electronic medical record for Resident #11, which revealed the Admission Agreement, Exhibit NJ E NJ Ex Order 26.4(b)(1 Policy. The signed and undated document revealed "Resident agrees to comply with the Facility's NJ Ex Order 26.4(b)(1 Policy ..." On 12/04/24 at 10:30 AM, Aurveyor #1 reviewed the electronic medical record for Resident #388. The current 11-page Care Plan did not include a care plan for NJ Exec Order 26.4b, and there was no NJ Exec Order 26.4b assessment. The Admission Agreement, last page #19 revealed: Exhibit NJ E Resident agrees to comply with the Facility NJ Exec Order 26.4b policy. The resident affirms that he/she has been provided a copy of the NJ Exec Order 26.4b1 Policy, has had the opportunity to read its contents, understand the NJ Exec Order 26.4b1 Policy and agrees to abide by the terms. The paper was signed and undated. On 12/04/24 at 12:11 PM, Surveyor #1 observed Resident #11 NJ Exec Order 26.4b1 in the courtyard. On 12/04/24 at 12:18 PM, Surveyor #1 interviewed Resident #54 who stated they NJ Ex Order 26.4(b) and the facility held the NJ Exec Order 26.4b1 On 12/06/24 at 1:52 PM, Surveyor #1 while in the main dining room and observing NJ Exec Order 26.4b area,	F 689		

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F 689	Continued From page 33	F 689		

asked the facility U.S. FOIA (b)(6)) and CNA #4 what the NJ Ex Order 26.4(b)(process was. The U.S. F stated that there were three residents who required a NJ Exec Order 26.4b1 for safety (Resident #63, #33 and an unsampled resident (UR #1) and that the CNAs would have an assignment for NJ Exec Order 26.4b. Surveyor #1 asked if there was a list so that the staff would know if a resident needed an a NJ Exec Order 26.4b1 and the U.S. FO stated it was posted on the NJ Ex Order 2 Wing. Surveyor #1 asked to see the list of residents who needed to wear an NJ Exec Order 2 and brought the surveyor to the NJ Exec Order Wing. The U.S. F stated the list was not there, only a list of times to NJ Ex Order 26.4 and went to the U.S. FOIA (b)(6)) to see the list and the U.S. FOIA was unable to provide a list. Surveyor #1 interviewed CNA #4 about the presence of a list for residents who were required to wear a NJ Exec Order 26.4b1 and she stated there was no list.

Surveyor #2:

On 12/04/24 at 9:26 AM, Surveyor #3 observed Resident #63 sitting in a wheelchair being propelled by staff, at that time, Resident #63 had a NJ Exec Order 26.4b1 .

On 12/04/24 at 11:00 AM, Surveyor #3 reviewed the electronic medical record (EMR) for Resident #63 and reviewed the Care Plan. The Care Plan had a Focus for NJ Ex Order 26.4(b)(that was initiated on NJ Ex Order 26.4(b)(1) The Goal was for Resident #63 to NJ Exec Order 26 safely through next review and be free from any NJ Ex Order2 through next review. Target Date: NJ Ex Order 26.4(b)(. An Intervention: NJ Ex Order 26.4(b)(1 supplies will be supplied. Initiated NJ Ex Order 26.4(b)(.

On 12/11/24 at 8:39 AM, Surveyor #3 observed Resident #63 in bed with one package of

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NJ Exec Order 26.4b1 observed on the table next to the bed. Resident #63 stated, they have NJ Exec Order 26.4b1 for the past 20 years.

On 12/12/24 at 8:50 AM, Surveyor #3 observed Resident #63 sitting in the dining room eating breakfast. Resident #63 stated that after breakfast they will go their room to get their NJ Exec Order 26.4b1
Surveyor #3:

On 12/05/24 at 9:42 AM, the surveyor observed the Certified Nursing Assistant (CNA #2) obtain a NJ Exec Order 26.4b1 from Resident #33's personal bag in presence of the surveyor. The surveyor observed a pack of NJ Exec Order 26.4b1 in the bag and Resident #33 stated that it was their NJ Exec Order 26 and had taken it from the CNA to go out to NJ Exec Order 26 Resident #33 stated "I keep my NJ Exec Order 26.4b1 with me all the time." The resident further stated, "all the residents have their NJ Exec Order 26.4b1 with them, and they take the NJ Exec Order 26 when they NJ Exec Order 26.4b1."

The surveyor reviewed the medical records of Resident #33 and revealed:

A review of the Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but were not limited to;
NJ Exec Order 26.4b1

A review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1

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revealed the Resident #33 had a Brief Interview for Mental Status (BIMS) of [NJ Exec Order 26.4b1], indicating the resident was [NJ Exec Order 26.4b1]. Section J "Health conditions" indicated that Resident #33 was a [NJ Exec Order 26.4b1].

A review of the Individualized Care Plan included a Focus area admitted to facility with a history of [NJ Exec Order 26.4b], with a Goal that resident will [NJ Exec Order 26] safely. Interventions included that [NJ Ex Order 26.4(b)(] supplies will be supplied during appropriate [NJ Ex Order 26.4(b)(] times. Smoking Rules & Agreement signed on [NJ Exec Order 26.4b]

On 12/12/24 at 8:33 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) #1 explained that the residents [NJ Exec Order 26.4b] under supervision. The staff was responsible to hold the [NJ Exec Order 2] when the resident went out to [NJ Exec Order 26] in the designated area. The [U.S. FOIA] further stated [NJ Exec Order 26.4b] schedules were listed at the nursing stations. The [U.S. FOIA] was not able to provide the surveyor information about where the [NJ Exec Order 26.4b1] were securely kept when not in use.

On 12/12/24 at 10:18 AM, during an interview with the surveyor, in the presence of the survey team, CNA #2 stated that no one had ever told him about [NJ Exec Order 26.4b] facility and he state, "I don't know how it works." The CNA acknowledged Resident #33 always held their [NJ Exec Order 2] and [NJ Exec Order 26.4b1] with them in the personal bag. The surveyor asked what residents had to wear the [NJ Exec Order 26.4b1] and CNA #2 stated, "I don't know about that".

On 12/12/24 at 12:23 PM, the survey team met with the [U.S. FOIA (b)(6)]

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F 689	Continued From page 36 DON and presented the above findings. On 12/12/24 at 03:01 PM, the survey team met with the U.S. FOIA (b)(6) for an exit conference. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-27.1(a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. 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 NJ Exec Order 26.4b1 equipment was stored and dated in accordance with professional standards when not in use for 1 of 1 resident (Resident #36) reviewed for NJ Exec Order 26.4b1 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 states: "The practice of nursing as a registered	F 695	Rose Mountain Care Center Facility ID 315384 Survey Date 12/12/24 F695 SS D Element One - Corrective Action: Resident #36 NJ Exec Order 26.4b1 , dated and placed in a labeled plastic bag. Element Two -Identification of at Risk Residents: All residents that utilize oxygen are at risk. An audit was completed on all residents utilizing oxygen to ascertain proper	12/25/24

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F 695	Continued From page 37 professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 12/3/24 at 9:17 AM, during an initial tour, the surveyor observed [redacted] in use signage posted on the door. The surveyor observed Resident #36 resting in their bed with [redacted], which was connected to an [redacted]. The [redacted] was not dated. On 12/4/24 at 9:30, the surveyor observed Resident #36 was not in their room. The surveyor observed Resident #36's [redacted] was placed on top of the [redacted]. The surveyor observed the [redacted] was not stored properly in a plastic bag when not in use.	F 695	labeling and storage when not in use on 12/12/24. ELEMENT THREE: SYSTEMIC CHANGES: All clinical staff were re-educated on labeling oxygen tubing with date and placing tubing in labeled, dated, plastic bags when not in use. QUALITY ASSURANCE To maintain and monitor ongoing compliance Unit Managers/designees will audit all residents utilizing oxygen weekly x4 and monthly x 3 to ensure all oxygen tubing is dated and when not in use is placed in labeled, dated plastic bag. Needed corrections will be addressed as they are discovered. Findings to be reported to Quality Assurance Performance Improvement team for review and action as necessary. Date of Completion: 12/25/24	

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F 695	Continued From page 38 On 12/4/24 at 10:02 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) #1 stated NJ Exec Order 26.4b1 were changed weekly by night shift staff as per facility policy. The U.S. FOIA (b) further stated the NJ Exec O would be stored in a special plastic bag and the bag would be labeled with resident's name and the date when it was changed. The U.S. FOIA (b) stated the residents were NJ Exec O and that's why it was important to change the U.S. FO and store it in a bag for NJ Exec Order 26.4b1 On 12/4/24 at 10:20 AM, during an interview with the surveyor, the U.S. FOIA (b)(6)) stated the U.S. FO was changed and dated weekly for cleanliness purposes and for infection control. The U.S. FOIA (b)(6) further stated NJ Exec would be placed in a plastic bag which would be labeled with resident's name and date. The U.S. FOIA (b)(6) stated if she observed a NJ Exec placed on top of the concentrator, she would replace the NJ Exec and place it in the plastic bag. At 10:26 AM, the surveyor informed the U.S. FOIA (b)(6) about the above findings. The U.S. FOIA (b)(6) accompanied the surveyor to Resident #36's room and disposed of the undated NJ Exec. The surveyor reviewed the medical record for Resident #36. According to the Admission Record, Resident #36 was admitted to the facility with diagnoses which included but was not limited to: NJ Exec Order 26.4b1 [redacted]	F 695		

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The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that Resident #36 was [redacted]. Further review of the MDS revealed the resident had used [redacted] while a resident.

A review of the resident's Care Plan (CP) included a focus area that indicated the resident is at risk for [redacted] related to: Diagnosis / History: [redacted]; Currently on [redacted] via [redacted] continuously initiated on [redacted]. A further review of the CP revealed that there was no plan or intervention on labeling the [redacted] after changing it weekly and how to store the [redacted] properly when [redacted] was not in use.

A review of Resident #36's Order Summary Report reflected a physician orders (PO) as follows: dated [redacted] continuously [redacted] via [redacted] every shift, and Change and Date [redacted] and [redacted] weekly every night shift every Sunday dated [redacted].

The above POs were transcribed to the [redacted] electronic medication administration record (eMAR) signed by a nurse "y" (yes) on Sunday [redacted] at night shift.

On 12/6/24 at 10:10 AM, during an interview with the surveyor, the [redacted]) stated [redacted] should be dated, placed in [redacted] when not in use and the [redacted] should not be touching the floor.

On 12/12/24 at 12:23 PM, the survey team met

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F 695	Continued From page 40 with the U.S. FOIA (b)(6) [redacted] The surveyor presented above mentioned concerns with the team. The surveyor reviewed the facility's undated policy titled "Oxygen Administration". The policy did not address the following: 1.) Labeling of O2 equipment and 2.) Proper storage of equipment when not in use. On 12/12/24 at 03:01 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] for an exit conference. The facility management did not provide additional information, and did not refute the findings.	F 695		
F 712 SS=F	NJAC 8:39-11.2(b) 27.1(a) Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician	F 712		12/25/24

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F 712	Continued From page 41 and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents a.) conducted face-to-face visits and wrote progress notes at least every thirty days for the first ninety days of admission, b.) were seen by the physician or nurse practitioner every thirty days with a physician visit at least every sixty days, and c.) documented an admission History and [redacted] ([redacted]) within 72 hours of a resident's admission to the facility. This deficient practice was observed for 4 of 18 residents and 1 closed record (Resident #13, #33, #81, #83 and #85) reviewed for physician visits. This deficient practice was evidenced by the following: 1. On 12/05/24 at 09:42 AM, the surveyor observed Resident #33 sitting in the wheelchair, in their room. The resident informed the surveyor that he/she did not see a [redacted] regularly. The resident stated I saw a [redacted] about 2 weeks ago and I did not know who he was, and he stated, "I am [redacted]". Resident #33 further stated "I saw him for the [redacted]." The surveyor reviewed the medical record (MR) for Resident #33. A review of the Admission Record (AR) revealed the resident was admitted to the facility with diagnoses which included but were not limited to;	F 712	Rose Mountain Care Center Facility ID: 315384 Survey Completion date 12-12-2024 F712 SS-F Physician visits-frequency/Timeliness/ALT NPP ELEMENT ONE: CORRECTIVE ACTION: It is the practice of the Center to ensure that all residents are seen by a physician every 30 days for the first 90 days and at least every 60 days thereafter. An audit was completed by the Regional DON of the last 30 days of physician visits to ensure that all physician visits were completed by their primary designated physician within the required time frame. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: The standard was not met for residents #13, #33, #81, #83 and #85. Any resident which is assigned to a physician has the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: All RN/LPN□s, Physicians and APNs were educated on the facilities policy regarding Physician visits. A certified letter was also sent to all Primary Physicians/APN□s to ensure they received a copy of the policy.	

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F 712	Continued From page 42 NJ Exec Order 26.4b1 [redacted]). A review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed the Resident #33 had a Brief Interview for Mental Status (BIMS) of NJ Exec Order 26.4b1 indicating the resident was NJ Exec Order 26.4b1 A review of the Electronic Medical Record (EMR) revealed a Physician Annual history and NJ Ex Order 26.4(b) (NJ Ex Order [redacted] note from the resident's attending physician with an effective date of NJ Exec Order 26.4 and had a created date of NJ Exec Order 26 The note was marked as a "Late Entry." 2. On 12/03/24 at 10:03 AM, during an initial tour, the surveyor observed Resident #81 watching TV in their bed. The surveyor reviewed the MR for Resident #81. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the quarterly MDS dated NJ Exec Order 26.4b1 revealed the resident had a BIMS of NJ Exec Order 26.4b1, indicating the resident was NJ Exec Order 26.4b1 [redacted]	F 712	QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Administrator/DON and or designee will audit monthly x 3 months, 10 random residents per unit and quarterly thereafter to ensure all primary physicians monthly visits are completed timely. Needed corrections will be addressed as they are discovered. Results will be reported to the QAPI team for review Date of Compliance: 12/25/24	

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F 712	Continued From page 43 A review of the EMR revealed an attending physician [redacted] note dated [redacted]. A review of the Physician progress notes (PN) revealed the attending physician documented a visit for the resident on [redacted]. Further review of the EMR revealed the U.S. FOIA (b)(6) also documented visits for the resident on [redacted] A review of the EMR did not reveal a PN from the attending physician or the attending [redacted] for [redacted] or that the physician and [redacted] were consistently alternating monthly visits. 3. On 12/5/24 at 12:00 PM, the surveyor observed Resident #13 sitting in their wheelchair, in the dining room. The resident was waiting for [redacted]. The surveyor reviewed the MR for Resident #13. A review of the AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of the Comprehensive MDS dated [redacted] revealed the Resident #13 had a Brief Interview for Mental Status (BIMS) of [redacted] indicating the resident was [redacted] A review of the EMR revealed an attending	F 712		

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	315384	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 712	Continued From page 44 physician [NJ Ex Orde] note dated [NJ Exec Order 26.4b] . It did not reveal any additional physician progress notes. A further review of the EMR revealed the resident was admitted to the facility in [NJ Exec Order 26.4b1] . On 12/11/24 at 11:31 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN #1) stated physicians make rounds every month for monthly visits and they document in EMR while at the facility. The [U.S. FOIA (b)] was unsure how soon the [NJ Ex Orde] would be completed for a new admission. On 12/11/24 at 11:43 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) stated [NJ Ex Orde] for a new admission should be done within 48 hours to 72 hours. The [U.S. FOIA (b)(6)] further stated the physician has to see their residents every 60 days. On 12/12/24 at 03:01 PM, the survey team met with the U.S. FOIA (b)(6) for an exit conference. The facility management did not provide additional information and did not refute the findings. 5. On 12/06/2024 at 8:25 AM, a surveyor observed Resident #83 in the main dining area. A review of the AR revealed that Resident #83 was admitted [NJ Exec Order 26.4b1] the facility. A review of the EMR Progress Notes (PN) documented a Late Entry [NJ Exec Order 26.4b1] , type: Physician [NJ Ex Orde] . The PN documented a chief complaint: [NJ Exec Order 26.4b1] . The remainder of the [NJ Ex Orde] contained areas such as [NJ Ex Orde] ROS (review of systems), Family History, Mod History/Diagnosis on file, Social History, [NJ Ex Order 26.4(b)] exam, diagnostics/labs, assessment, and Plan of Care	F 712		

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F 712	Continued From page 45	F 712		

(draft) were all blank. A review of the Late Entry Draft assessment revealed the effective date as [NJ Exec Order 26.4b] but the created date as [NJ Exec Order 26]. The assessment also contained the chief complaint, but all other assessment areas were blank.

On 12/11/2024 at 11:36 AM, the [U.S. FOIA (b)(6)] on the [NJ Exec Order] Unit stated that upon admission, the staff would call the doctor. The expectation would be that the doctor would be in to see the resident for an [NJ Ex Orde] within 24 to 48 hours.

6. On 12/03/24 at 4:07 PM, a surveyor conducted a closed medical record review of Resident #85's electronic medical record (EMR). The EMR revealed a nursing progress note that on [NJ Exec Order 26.4b] Resident #85 was [NJ Exec Order 26.4b1] with a [NJ Exec Order 26.4b1] referral made.

On [NJ Ex Order 26.4(b)(1)] at 12:33 the Physician completed a History and [NJ Ex Order 26.4(b)(1)] which revealed the following physician note:

Effective Date: [NJ Exec Order 26.4b1] (completed 3 days after the resident [NJ Exec Order 26.4b1]
Type: Physician [NJ Ex Orde]
Cheif Complaint:
[NJ Ex Orde] Patient evaluated at side, spoke to [spouse], has history of [NJ Exec Order 26.4b1]. All questions and concerns answer with [spouse]. ... is [NJ Exec Order 26.4b1]. Spoke to nurse and reviewed chart no concerns at this time

Time spent, including counseling and coordination of care: 50 minutes
Rendering Provider,
[Physician Name]

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F 712	Continued From page 46 Author: [Physician Name] - Physician [e-SIGNED] On 12/11/2024 at 11:43 AM, a physician who has residents at the facility was on the telephone with the survey team. The physician stated that he had been one of the physician's at the facility for "2 to 3 years" and that upon a resident's admission, the resident should be seen within 48 hours. On 12/12/2024 at 2:10 PM, the survey team conducted a telephone interview with the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA was asked about his expectations regarding physician's at the facility entering late entry notes months after the supposed visit with the resident. The U.S. FOIA specified that the notes should be entered into the EMR immediately. The survey team asked the U.S. FOIA if it was appropriate for a physician to document an actual visit progress note after a resident was discharged and the U.S. FOIA stated, "no", because the resident was not there. On 12/12/24 at 12:23 PM, the survey team met with the U.S. FOIA (b) (6) [redacted]. The surveyor presented above mentioned concerns with the team. At 3:01 PM, during exit conference, the facility had no additional information to provide. The surveyor reviewed the facility's policy titled "Physician Visits" with last revised date of 4/2008 included under Policy Statement: The Attending Physician must make visits in accordance with applicable sate and federal regulations. Under Policy Interpretation and Implementation: 1.) The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety	F 712		

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F 712	Continued From page 47 (90) days following the resident's admission, and then at least every sixty (60) days thereafter. 2. After the first ninety (90) days, if the Attending Physician determines that a resident need not be seen by him/her every 30 days, an alternate schedule of visits may be established, but not to exceed every 60 days. A Physician assistant or nurse practitioner may make alternate visits after the initial 90 days following admission, unless restricted by law or regulation. The facility policy failed to address the physician visit upon admission. The surveyor reviewed the facility provided undated "Guidelines for Charting and Documentation" included under Physician Orders 1. a.) Each resident must be under the care of a licensed physician authorized to practice medicine ....and must be seen by the physician at least every thirty (30) days for the first ninety (90) days after admission and at least once every sixty (60) days thereafter. NJAC 8:39-11.2(c); 23.2(a)(d)	F 712		
F 838 SS=E	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a	F 838		12/25/24

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F 838	Continued From page 48 substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing	F 838		

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F 838	Continued From page 49 and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the	F 838		

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F 838	Continued From page 50 appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to ensure the facility-wide assessment included a) an assessment of the needs of the population of residents who [redacted] and included policy, services, and staff competencies for those residents, and b.) for the [redacted] populations which identified ethnic, cultural, religious preferences and staff competencies. The deficient practice affected residents who resided on both the [redacted]	F 838	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 F838 SS-E Facility Assessment Element One: All staff were immediately educated on the smoking policy and process. A newspaper	

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F 838	Continued From page 51 wing of the facility and was evidenced by the following: Refer to F679 and F689 On 12/03/2024 at 8:50 AM, two surveyors were present in the conference room and requested the surveyor information from the U.S. FOIA (b)(6) regarding residents who NJ Exec Order 26.4b1 the NJ Exec Order 26.4b policy, and NJ Exec Order 26.4b times. On 12/03/2024 at 9:34 AM, in the presence of the two surveyors, the U.S. FOIA (b)(6) provided NJ Ex Order 26.4(b)(hours, a list of NJ Exe residents who NJ Exec Order 26, and a document " NJ Ex Order 26.4(b)(1 Rules and Agreement". When asked about the smoking policy, the U.S. FOIA (b)(6) explained that the "NJ Ex Order 26.4(b)(1 Rules and Agreement" was the facility policy. On 12/03/2024 at 9:55 AM, entrance conference was conducted with the U.S. FOIA (b)(6). At that time, additional survey documents were provided which included but were not limited to; the Facility Assessment Tool. 1. On 12/04/2024 at 9:40 AM, the U.S. FOIA (b)(6) was asked the process for resident's who NJ Ex Order 26.4 and that she did not hold any resident NJ Exec Order 26.4b1. The U.S. FOIA stated she did not care for any residents who NJ Exec Order 26.4b and that maybe the NJ Exec Order 26.4b1) kept the resident NJ Exec Order 26.4b1. On 12/04/2024 at 9:44 AM, the U.S. FO stated that the nurses were responsible to hold the resident's NJ Exec Order 26.4b1. On 12/04/2024 at 9:50 AM, during an interview	F 838	was immediately ordered for the resident. The facility assessment was updated ensuring all resources necessary for the care of the residents are documented Element Two: All residents who smoke and the residents from the asian population had the potential to be affected by the deficient practice. Element three: All staff were educated regarding the facilities smoking policy and process. The activity staff and admissions staff were educated to inform the administrator if there are any delays in the newspaper being delivered. The facility Administrator was educated by the Regional Administrator on the facility assessment requirements and ensuring all resources necessary for the care of the residents are documented. The residents were explained the importance of smoking safety and following the rules. They were educated about not holding their cigarettes and lighters as well as the designated smoking times. The residents were also educated on the facility's smoking policy and process. Element Four: The Administrator / designee will continue to monitor the smoking program to ensure safety. The Administrator will review the facility assessment monthly x 3 then	

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F 838	Continued From page 52 regarding the smoking process with a Certified Nursing Assistant (CNA), the CNA stated, "I don't know the process" and believed the NJ Exec Order 26.4b1 were kept with the nurses. On 12/05/2024 at 9:42 AM, CNA #2 was observed NJ Exec Order 26.4b1 out of a resident's personal bag in their room, which also contained a NJ Exec Order 26.4b1. At that time, the surveyor followed as the NJ Exec Order 26 was given to Resident #33. Resident #33 informed the surveyor, "I keep my NJ Exec Order 26.4b1 all the time." The resident further stated, "all the residents have their NJ Exec Order 26.4b1, and they take the NJ Exec Order when they NJ Exec Order 26.4b1." On 12/06/2024 at 1:52 PM, the surveyor was observing the NJ Exec Order 26.4b1 which was visible from the main dining area. The U.S. FOIA (b)(6) was present and stated there was a list of three residents who required U.S. FOIA (b)(6) and that the CNAs had an assignment for NJ Exec Order 26.4b observation. The U.S. FOIA (b)(6) stated the list was posted on the NJ Exec Orde unit. The U.S. FOIA (b)(6) and surveyor went to the NJ Exec Orde unit but were unable to find the list. The surveyor asked CNA #4 about the list and was informed there was no list. 2. On 12/03/2024 at 9:58 AM, the surveyor observed Resident #25 lying in bed with a family member present. The family member expressed concern that the resident was supposed to be receiving a daily newspaper in their NJ Ex Order 26.4(b)(1) of NJ Exec Order 26.4b but that was not happening. On 12/04/2024 at 12:28 PM, the surveyor was in the main dining room and observed residents of NJ Exec Order 26.4b1 culture. The surveyor also	F 838	quarterly as well as updating it on an as needed basis. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	

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F 838	Continued From page 53 observed a menu and activities calendar in [redacted]. On 12/5/2024 at 9:35 AM, the surveyor observed Resident #25 lying in bed with no newspaper present. On 12/5/2024 at 9:49 AM, the [redacted] stated that she was familiar with the resident and that the resident was supposed to get the special newspaper, but she was not sure who was supposed to provide the newspaper. A review of the facility provided, "Facility Assessment Tool" dated 8/2024, included but was not limited to; Resident Profile which indicated the facility was licensed for [redacted] residents. 1.4 The admission of a resident or continuation of care with certain conditions, diagnoses or needs ... to ensure the facility has the appropriate equipment, training/education and staff to provide care to ensure residents shall receive necessary care and service to attain or maintain highest practicable, physical, mental, and psycho-social well-being. On 12/12/2024 at 12:58 PM, the [redacted] and administrative team were made aware that the Facility Assessment did not address the cultural needs of the [redacted] population, the [redacted] needs of the residents, and the lack of staff knowledge with [redacted] to follow. On 12/12/2024 at 3:01 PM, the survey team met with the facility administrative team. The facility had no additional information to provide regarding the facility assessment. NJAC 8:39-7.3(a)(g); 27.1(a)(b)	F 838		

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F 847 SS=F	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.	F 847		12/25/24

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F 847	Continued From page 55 §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the facility failed to ensure that residents were explicitly informed of and understanding was assessed prior to having the residents enter into a arbitration agreement which was identified as a mandatory part of the Admission Agreement for 9 of 9 Residents who attended a resident council meeting (Resident #6, #11, #20, #21, #24, #27, #40, #71, #78) and was evidenced by the following: On 12/03/24 at 10:07 AM, during the facility entrance conference held with the U.S. FOIA (b)(6) [redacted] The surveyor asked if the facility utilized arbitration agreements. The U.S. FOIA (b)(6) stated "absolutely", we offer arbitration and it is in their admission agreement. The U.S. FOIA (b)(6) then stated, "but it is a separate area, and it is overseen by legal." The surveyor requested a list of all the residents that had signed the arbitration agreements. The U.S. FOIA (b)(6) stated there is no one in an active arbitration agreement, and stated the U.S. FOIA (b)(6) was responsible for the arbitration agreements.	F 847	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 F847 SS-F Entering into Binding Arbitration Agreements Element One: Corrective Action The Admissions director signed and dated Exhibit 1 The facility immediately modified the agreement making it very clear to prospective residents that the agreement is completely voluntary and not a condition of admission or continued care at the facility. Element Two: Identification Of At Risk Residents All residents had the potential to be affected by the deficient practice.	

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	315384	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 847	Continued From page 56 On 12/03/24 at 10:30 AM, the surveyor reviewed the survey binder provided by the administration which revealed under the arbitration agreement section, a typed document revealed:[facility name] does have any current resident that have entered into a binding arbitration agreement. The survey binder included a copy of the 19 page Admission agreement which revealed the following: k. Arbitration: All claims arising out of this Agreement must be handled pursuant to the terms of the annexed "Mandatory Arbitration Sub-Agreement". By signing this Agreement Resident/Sponsor expressly confirms having reviewed the Agreement and Mandatory Arbitration sub-agreement and agree to all the terms in their entirety including the terms of the annexed Mandatory Arbitration sub-agreement. Resident expressly agrees to having had the opportunity and time to read the Argeement and Mandatory Arbitation Sub-Agreement in their entirety and to having the option of having both reviewed by an attorney of Resident's choice prior to signing. Page 8 of the Admission Agreement revealed Resident/Sponsor confirms that these exhibits were provided to resident prior to signing of the Admission Agreeement and that such exhibits are part of the Admission Agreement. Index of Exhibits: Resident/Sponser Initials: Exhibit 1- Mandatory Binding Arbitration Agreement. Exhibit 1 (Page 9) revealed: Mandatory Binding Arbitration Sub-Agreement. Arbitration Explained: Arbitration is a specific process of dispute resolution instead of utilizing the traditional state or federal court system. Instead of a judge and/or jury determining the outcome of a dispute ... Mandatory arbitration has been selected with the goal of reducing the time, formalities and cost of utilizing the court system ... Page 11 of the AA revealed "I agree to the terms	F 847	Element three:Systemic Changes The U.S. FOIA (b) (6) was educated on explaining the agreement in a form and manner that the prospective resident or representative fully understands. Element Four: Quality Assurance The Administrator / designee will observe and monitor the Admissions director while explaining the admission agreement and arbitration agreement to residents / families and ensure that the Admissions Director explains what arbitration is and answers all questions they may have appropriately weekly x4 then monthly x2. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	

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F 847	Continued From page 57	F 847		

Mandatory Arbitration Sub Agreement in it's entirety (Subsections A-K). I acknowledge and confirm that I was given ample opportunity to read the Mandatory Arbitration Sub-Agreement in its entirety, that I have in fact read and understood the Mandatory Arbitarion Sub-Agreement and had the opportunity to have it reviewed by an attorney of my choosing prior to signing". Print Resident Name, Signature Line and Faciltiy Admission Director signature and date. There was no option to refuse the agreement contained within the Admission Agreement.

On 12/03/24 at 11:22 AM, the facility [redacted], in the presence of the [redacted] addressed the survey team regarding the requested entrance documents and the list of residents who entered into an arbitration agreement. The [redacted] stated there was an arbitration agreement and there is an admission agreement and "obviously" everyone signs the admission agreement. The [redacted] stated, "we don't track" who signed the arbitration agreements and "we have no way" to track them. The [redacted] stated we can go manually and track them and the [redacted] stated, "we would have to track them manually and it would be a slow process."

On 12/04/24 at 11:06 AM, a resident council meeting was conducted with nine residents (Resident #6, #11, #20, #21, #24, #27, #40, #71, #78). The surveyor asked the residents if they had been aware of what an arbitration agreement was and 9 of 9 responded, "no". The surveyor asked if anyone had explained it to them and 9 of 9 residents responded, "no". The surveyor then asked if the residents had signed an arbitration agreement during the admission process and 9 of

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F 847	Continued From page 58 9 residents responded "yes." On 12/04/24 at 1:00 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #11. The EMR revealed the Admission Agreement was signed on [NJ Exec Order 26.4(b)] by the Resident and the [U.S. FOIA], and Exhibit 1 was signed by the resident and undated and was not signed by the Admission Director. On 12/04/24 at 1:52 PM, the Surveyor interviewed the [U.S. FOIA (b)(6)]), in the presence of the survey team and [U.S. FOIA (b)(6)].The surveyor asked what the admission process was and the [U.S. FOIA] stated they worked with all departments to confirm the admission and then met with the family to explain resident rights, smoking and they sign the Admission Agreement(AA). On 12/04/24 at 1:55 PM, the surveyor showed the [U.S. FOIA] the AA and asked her what the Mandatory Binding Arbitration Agreement (AA) was. The [U.S. FOIA] stated if the resident had a complaint, we discuss it at the facility. The surveyor asked if the [U.S. FOIA] director read over and explained the AA as part of the admission process. The [U.S. FOIA] stated, "they can read it" and ask questions if they have questions. The surveyor asked the [U.S. FOIA] what the Mandatory part of the AA was and the [U.S. FOIA] stated, "it must be signed". The surveyor asked if the [U.S. FOIA] had a list of residents who either signed the agreement or refused to sign it and she stated she did not. NJAC 8:39-4.1(b)	F 847		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/25/24

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F 880	Continued From page 59 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 60 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documentation, it was determined that the facility failed to a.) ensure a process was in place to identify residents who were on [NJ Ex Order 26.4(b)(1)) NJ Ex Order 26.4(b)(1)], by posting clear signage outside of resident rooms indicating the type of Protective Personal Equipment (PPE) to be worn and defining the [NJ Ex Order 26.4(b)] resident care activities associated with	F 880	Rose Mountain Care Center Facility ID 315384 Survey Date 12/12/24 F880 SS-F Infection Control and Prevention ELEMENT ONE: CORRECTIVE ACTION All staff were in-serviced on the process	

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F 880	Continued From page 61 NJ Ex Orde for 8 of 8 NJ Ex Orde rooms, b.) provide residents with hand hygiene (hh) and ensure staff performed hh in between serving and setting up residents with meals, c.) remove contaminated gloves prior to walking around in a non-clinical area, the dining room and making contact with multiple residents, d.) ensure the ice containers on 2 of 2 units were dated and had self-draining holders, and e.) use hh after touching a cell phone and prior to assisting to feed a resident who was NJ Ex Order 26.4(b)(1) on staff for eating for 1 resident (Resident #48). This deficient practice was evidenced by the following: 1. On 12/04/24 at 12:28 PM, the surveyor observed a resident room on the NJ Exec Orde unit with an orange dot sticker next to a Resident #21's name. The surveyor asked the Certified Nursing Assistant (CNA) #1 what the orange sticker meant. CNA #1 replied that it meant the resident was "on a NJ Exec Order 26.4b1 ". CNA #1 stated he had worked at the facility full-time for about 1 year. There was no other signage on the resident's door and no PPE available by the room entrance. A review of the Admission Record (AR) revealed Resident #21 was admitted with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the Care Plan included a focus area that Resident #21 was on NJ Ex Orde due to NJ Exec Order 26.4b1 with interventions that included ensure PPE is accessible and ensure PPE is worn during NJ Ex Order2 care.	F 880	and identification of residents on Enhanced Barrier Precautions (EBP) on 12/3/2024. The family/residents on EBP were educated on the precautions and why they are utilized. All staff that pass out food trays were re-in serviced on 12/3/24-12/5/24 on hand hygiene for both residents and staff pre, post meal and when passing out trays. In addition, staff were re-inserviced on not leaving garbage including cup lids The therapist who was observed in the hallway with gloves was inserviced immediately. The self-draining holders were installed in both units on 12/12/24. C.N.A. #2 was immediately re-in serviced and counseled on zero tolerance on phone use as per facility policy, and in employee handbook, educated upon hire, annually, and as evidenced by C.N.A. signature in employee handbook. In addition, c.n.a.#2 was re-in serviced on sitting level with resident while assisting with meals. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents on EBP have the potential to be affected. All residents that require hand hygiene prior to meals and require assistance with meals can be affected.	

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F 880	Continued From page 62 On 12/05/2024 at 8:35 AM, Surveyor #1 observed a resident room on the U.S. FOIA (b) unit with signage for NJ Ex Order 26.4(b)(1), stop and see the nurse, how to don (put on) and doff (remove) PPE, and the steps to take for care, housekeeping, transporting, workflow, and visitor instructions. There was a bin with PPE available outside the resident's door. During observations on both units, Surveyor #1 observed the NJ Exec Order 26.4b1 unit had a total of 8 resident rooms with an orange dot sticker next to a resident name. Surveyor #1 observed that PPE bins were not readily available outside those resident doors. On 12/05/2024 at 10:09 AM, Surveyor #1 requested all Transmission Based Precaution (TBP) categories, the signage and the precautions required with each TBP used in the facility. The Vice President of Clinical Services (VPC) #1 provided Surveyor #1 with only the NJ Ex Orde policy at that time. Surveyor #1 questioned the other TBP categories and the signage for NJ Ex Order VPC #1 stated that the NJ Ex Orde rooms only needed an orange dot and no signage. Surveyor #1 asked about how staff and visitors would know what to wear or what precautions to take. Surveyor #1 inquired what if a visitor was to assist a resident to the bathroom or with dressing? VPC #1 replied the facility does not encourage visitors to assist residents. On 12/06/2024 at 10:10 AM, the U.S. FOIA (b)(6) [redacted] in the presence of three surveyors stated that NJ Ex Orde was an "extra precaution" and not NJ Ex Order 26.4(b)(1 She stated that the PPE was located at the nurses station and that if visitors did not stop at the	F 880	All residents who receive ice have the potential to be affected. All residents can be affected by staff personal cell phone use. ELEMENT THREE: SYSTEMIC CHANGES: All staff were inserviced on the process and identification of residents on Enhanced Barrier Precautions (EBP) on 12/3/2024. The family/residents were educated on the precautions and why they are utilized. Moving forward EBP will be discussed for residents/family to remind them of the precautions and their purpose at the residents care plan meeting. All staff that pass out food trays were re-in serviced on 12/3/24-12/5/24 on hand hygiene for both residents and staff pre, post meal and when passing out trays. In addition, staff were re-inserviced on not leaving garbage including cup lids The U.S. FOIA (b) (6) who was observed in the hallway with gloves was inserviced immediately. The self-draining holders were installed in both units on 12/12/24. C.N.A. #2 was immediately re-in serviced and counseled on zero tolerance on phone use as per facility policy, and in employee handbook, educated upon hire, annually, and as evidenced by C.N.A.	

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F 880	Continued From page 63 nurses station to ask, they would not know that the orange dot indicated [NJ Ex Order] She stated that the staff was all aware that PPE was required for direct care. Surveyor #1 inquired if tasks such as changing linens and dressing required PPE. The [U.S. FOIA (b)(6)] stated the staff were aware. The surveyor made the [U.S. FOIA (b)(6)] aware of the interview with CNA #1 who was not aware of the meaning of the orange dot and it's precautions. Surveyor #2 asked if the facility followed the Centers for Disease Control and Prevention (CDC) guidelines. The [U.S. FOIA (b)(6)] stated yes. Surveyor #1 requested the facility staff education regarding [NJ Ex Order] with the education material that was used. A review of the facility provided staff sign in sheets revealed that on 03/28/2024, CNA #1 signed in as having watched a video about [NJ Ex Order] There was no educational material provided. The facility provided [NJ Ex Order] precautionary signage, but the signage was not posted on any [NJ Ex Order] doors. The signage specified Stop. NJ Ex Order 26.4(b)(1) [redacted] everyone must: clean their hands before entering and when leaving; providers and staff must wear gloves and gown for following dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use and wound care. The facility provided a link to an Internet [name redacted] video on [NJ Ex Order] A review of the facility provided policy, "Enhanced Barrier Precautions (EBP)" effective 4/1/24, included but was not limited to; Statement ... implementing effective measures to prevent the transmission of multi-drug resistant organisms within our facility. Procedures: EBP is employed	F 880	signature in employee handbook. In addition, c.n.a.#2 was re-in serviced on sitting level with resident while assisting with meals. A visual audit of meal pass was completed daily x 5 days starting 12/5/2024 at various mealtimes to assess any staff members that may not be practicing proper hand washing with residents and when passing out trays, as well as when assisting residents to eat, staff is sitting. The Director of Nursing/Licensed Nursing Home Administrator completed daily facility rounds at different times to audit staff personal cell phone use. ELEMENT FOUR: QUALITY ASSURANCE: The infection preventionist will audit the residents on EBP monthly x 3 months and then quarterly. Food Service Director/Dietician/Designee will visually audit (and document) dining services at various times/meals to assess staff compliance with resident and staff hand hygiene, and staff are sitting when assisting resident with meals, daily x 5, weekly x4 and monthly x3. Needed corrections will be addressed as they are discovered. Findings to be reported to the QAPI team for review and action as necessary.	

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F 880	Continued From page 64 when performing high-contact activities: dressing, bathing/showering, transferring, hygiene, changing linens, changing briefs, or assisting with toileting, device care, and wound care. 3. Training and Education: all HCP (health care providers) will receive training on identification, management, and prevention ... including use of contact precautions and EBP "*identified as orange dot on resident door name." regular education and updates will be provided to ensure compliance. A review of the "CDC Long-term Care Facilities (LTCFs) Frequently Asked Questions about NJ Ex Order 26.4(b)(1) in Nursing Homes" dated 06/28/2024, included but was not limited to; "28. Does posting signs specifying the type of precautions and recommended PPE outside the resident room violate ... resident dignity? No. Signs are intended to signal to individuals entering the room the specific actions they should take to protect themselves and the residents. To do this effectively, the sign must contain information about the type of precautions and the recommended PPE to be worn when caring for the resident. Generic signs that instruct individuals to speak to the nurse are not adequate to ensure precautions are followed. Signs should not include information about the resident's diagnosis or the reason for the precaution (e.g. presence of resistant pathogen); inclusion of that information would violate HIPAA (Health Insurance Portability and Accountability Act) and resident dignity." A review of the facility provided policy, "Infection Control" undated, included but was not limited to; 5. The Administrator or Governing Board ... had adopted the infection control policies and	F 880	DATE OF COMPLIANCE:12/25/24	

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practices as outlined to reflect the facility's needs .. for preventing transmission of infections ... as set for in .. CDC guidelines and recommendations. Nursing: 7. Places a sign on the resident's door including please see nurse before entering. All staff: 8. Contact nurse before entering the room for what PPE is needed to perform the task. 9. Without violating HIPAA, notify staff member what precautions are needed. 11. Educates resident and family regarding proper infection control techniques to prevent the spread of infection.

2. On 12/03/2024 from 11:45 AM through 12:23 PM. Surveyor #1 and Surveyor #2 observed the lunch meal in the main dining room. The surveyors observed the following:

At 12:05 PM, a resident entered into the dining room from the door to the NJ Exec Order 26.4b1. The resident opened the NJ Exec Order 26.4b1, touched their chair and cell phone. Two additional residents from the NJ Ex Order 26.4(b)(area entered the dining room. The staff delivered the three resident's their meal trays but did not offer any hh and there was no form of hh available on the trays.

At 12:13 PM, a staff identified as LPN #2 delivered a tray to a resident and walked over into the NJ Exec Orde unit. LPN #2 passed 3 alcohol-based hand rub (ABHR) dispensers and did not perform hh. LPN #2 obtained another tray and handed the tray to another staff member. Next LPN #2 obtained another tray, walked into the dining room and handed that tray to a different staff member. LPN #2 next assisted to move a resident in their wheelchair. LPN #2 did not perform hh between handling the food trays or

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before or after assisting the resident.

At 12:17 PM, LPN #2 failed to perform hh, picked up a tray and handed the tray to a staff member. LPN #2 next took a tray and delivered the tray to one resident at a table of four residents. LPN #2 began opening up items for one of the other residents at the table without performing hh.

At 12:23 PM, LPN #2 stated that the process was to use hh for the residents and staff, to set up trays and if passing a tray to another resident, "I must clean my hands to prevent germs."

A review of the facility provided policy, "Handwashing/Hand Hygiene" undated, included but was not limited to; statement ... hand hygiene the primary means to prevent the spread of infection. 5. Employees must wash their hands for at least 20 seconds ... under the following conditions: g. before and after assisting a resident with meals; 6. In most situations, the preferred method of hh is with ABHR ... for the following situations: a. before and after direct contact with residents.

On 12/12/2024 at 12:44 PM, the above concerns were addressed with the facility administrative team. Surveyor #1 requested the policy for resident meal service. The surveyor was provided the dietary department policy. The surveyor clarified which policy was requested. The facility did not provide the policy nor any additional information.

3. On 12/03/2024 at 11:52 AM, staff identified as the U.S. FOIA (b)(6)) walked with a resident using a walker, from the NJ Ex Order 26.4(b)(1), through one small dining area, into the main

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

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dining room and to a table. The [redacted] was wearing PPE gloves the entire time. The [redacted] next placed her gloved hand on another resident's right shoulder. The [redacted] went to a third resident and held that resident's hand with her gloved hand. The [redacted] removed her gloves after having contact with all three residents and their surroundings.

At 11:58 AM, the [redacted] stated that she was wearing gloves because sometimes the resident she was assisting, can be "soiled". The [redacted] stated she had forgotten to remove the gloves before interacting with the other two residents. She stated it was important to remove the gloves because it could cause the spread of infection.

A review of the CDC The National Institute for Occupational Safety and Health (NIOSH), "Donning and Doffing PPE: Proper Wearing, Removal, and Disposal" last reviewed 10/3/2022, included but was not limited to; remove PPE before entering any non-clinical areas.

4. On 12/04/2024 at 9:03 AM, Surveyor #2 observed an uncovered cup next to a small ice chest on the [redacted] unit. The ice bin was filled and there was a sticker dated "12/3/24". During an interview at that time, the NJ Exec Order 26.4b1 stated, "they forgot to change the sticker" and pulled off the dated sticker.

On 12/04/2024 at 9:30 AM, Surveyor #2 observed an uncovered pink drink pitcher next to a container of ice on the [redacted] unit. The ice scoop was not self-draining.

A review of the facility provided policy, "Ice Machines and Ice Storage Chests" revised 04/2012, included but was not limited to;

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statement: ice machines and storage/distribution containers will be used and maintained to assure safe and sanitary supply of ice. Methods of contamination: d. improper storage or handling of ice. Preventing contamination: g. uses a smooth-surface ice scoop to obtain and dispense the ice; h. keeps the ice scoop and bin in a covered container when not in use; k. if another receptacle such as a small chest or bin is used ... do not distribute ice directly from an open container.

On 12/12/2024 at 12:44 PM, the above concern was presented to the facility. The facility did not provide any additional information.

5. On 12/12/2024 at 8:11 AM, Surveyor #1 observed CNA #2 sitting in a chair next to the Resident #48 lying in bed. On the overbed table, Surveyor #1 observed the partially eaten breakfast meal. Surveyor #1 further observed that CNA #2 was actively texting on her cell phone. As the surveyor entered the room, CNA #2 closed the cell phone case and began assisting to feed Resident #48 the rest of their breakfast without performing hh.

On 12/12/2024 at 8:17 AM, CNA #2 stated that she should not have been on her cell phone. She stated she should have used hh after using her cell phone and prior to resuming feeding the resident for infection control reasons.

A review of the facility provided In-Service: Handwashing dated 11/28/2024, included but was not limited to; CNA #2's signature that she had attended the education which included but was not limited to; protect yourself and patients from deadly germs by cleaning your hands. clean your

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F 880	Continued From page 69 hands: when moving from soiled to clean ... on the same patient ... A review of the facility provided policy, "Handwashing/Hand Hygiene" undated, included but was not limited to; statement ... hand hygiene the primary means to prevent the spread of infection. 6. ABHR is the preferred method for the following situations: a. before and after direct contact with residents; i. after contact with objects in the vicinity of the resident. NJAC 8:39-19.4(a)(m)(n); 19.6(d); 27.1(a); 27.5(c)	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/4/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure corner guards were free from sharp edges and failed to provide protective endcaps to corner guards. This deficient practice had the potential to affect all residents on the east wing and was evidenced by the following: An observation at 2:27 PM with the [redacted], revealed two metal corner guards by the handrails in the main dining room had a sharp edge and no protective endcaps installed to prevent an injury. In an interview at the time, the [redacted] confirmed the	F 921	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 F921 SS-E Safe/Functional/Sanitary/Comfortable Environment Element One: On 12-4-24 The Maintenance director installed protective endcaps to the corner guards by the handrails in the main dining	12/25/24

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F 921	Continued From page 70 findings. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 12/5/2024 at 2:45 PM. NJAC 8:39-31.4(a)	F 921	room. Element Two: All residents had the potential to be affected by this deficient practice. Element three: The U.S. FOIA (b) (6) was educated to ensure corner guards are free from sharp edges to prevent an injury Element Four: The Maintenance Director/Designee will audit the handrails ensuring protective endcaps are installed and properly functioning, weekly x4 then monthly x2 months. Results will be reported to the QAPI team for review Completion Date: 12-25-2024	

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{F 000}	INITIAL COMMENTS Survey Date: 12/12/24 Revisit Date: 2/11/25 Census: 82 Sample: 7 A Revisit 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 679} SS=F	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: NOT CORRECTED Based on interview, and review of pertinent documentation, it was determined that the facility failed to have a system in place to monitor resident participation and response to activities in order to ensure activities are provided for a meaningful resident quality of life. This deficient practice was identified for 7 of 7 residents	{F 679}	F679 Element One □ Corrective Actions A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #1. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and	3/5/25

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

Electronically Signed | 02/27/2025

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{F 679}	Continued From page 1 (Resident #1, #2, #3, #4, #5, #6, #7) reviewed for activities, had the potential to affect all residents who resided in the facility and was evidenced by the following: On 2/11/25 at 8:56 AM, Surveyor #1 and Surveyor #2 entered the facility common area and observed 14 residents on one side of the room and 10 on the other side of the room. There was one white board that identified three scheduled activities for the day which included 9:00 AM Coffee Hour, 11:00 AM Connect the Dots, 1:00 PM Basketball, and 3:00 PM - 4:00 PM residents choice. A review of the NJ Ex Order 26.4(b)(1) Activity Calendar posted on both the NJ Ex Order and NJ Ex Order unit, included notations on the bottom that there would be coffee/tea every morning at 9:00 AM and the "Calendar subject to change". On 2/11/25 at 10:00 AM, Surveyor #1 reviewed the following electronic medical records: A review of the Admission Record (AR) an admission summary indicated that Resident #1 had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) A review of the Annual Minimum Data Set (MDS) an assessment tool to facilitate care dated NJ Ex Order 26.4(b)(1), included but was not limited to; a Brief Interview for Mental Status (BIMS) of NJ Ex out of 15 which indicated NJ Ex Order 26.4(b)(1) . The MDS further documented that it was "somewhat important" to Resident #1 to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), be in a NJ Ex Order 26.4(b)(1), go to their NJ Ex Order 26.4(b)(1), go NJ Ex Order 26.4(b)(1) and participate in NJ Ex Order 26.4(b)(1). The individual comprehensive care plan (ICCP)	{F 679}	preferences of Resident #1 and activity staff were re-educated about the changes. A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #2. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and preferences of Resident #2 and activity staff were re-educated about the changes. A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #3. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and preferences of Resident #3 and activity staff were re-educated about the changes. A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #4. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and preferences of Resident #4 and activity staff were re-educated about the changes. A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #5. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and preferences of Resident #5 and activity staff were re-educated about the changes.	

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{F 679}	Continued From page 2 initiated NJ Ex Order 26.4(b)(and revised on readmission NJ Ex Order 26.4(, documented Resident #1 likes NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) and that the "care plans remain appropriate". A review of the quarterly Activity Participation Review (APR) dated NJ Ex Order 26.4(included but was not limited to; includes a section to "describe the resident's NJ Ex Order 26.4(b)(1) preferences and participation level with activities ... relevant NJ Ex Order 26.4(b)(1), ... new interests", resident is NJ Ex Order 26.4(b)(1) daily, participates in activities of their choice and enjoys NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(The APR further documented that the focus(es) was "current as per care plan". A review of the AR for Resident #2 indicated that the resident had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A review of the Annual MDS dated NJ Ex Order 26.4(b)(, included but was not limited to; a BIMS of NJ Ex out of 15 which indicated NJ Ex Order 26.4(b)(1) . The MDS further documented that it was "very important" to NJ Ex and it was "somewhat important" to have NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), be NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), do things with groups of people, go to their favorite activities, and participate in NJ Ex Order 26.4(b)(1). The ICCP failed to address Resident #2's activity preferences. A review of the quarterly APR dated NJ Ex Order 26.4(b) included but was not limited to; includes a section to "describe the resident's attendance preferences and participation level with activities ... relevant NJ Ex Order 26.4(b)(1), ... new interests", spends time NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and will attend NJ Ex Order 26.4 of their choice. The APR further documented that the focus(es) was "current as per care plan", goals were met, and	{F 679}	A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #6. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and preferences of Resident #6 and activity staff were re-educated about the changes. A Certified Activities Director reviewed, revised as appropriate, and signed the activity participation review (APR) for Resident #7. The care plan was also reviewed and updated as needed to reflect the current interests, abilities, and preferences of Resident #7 and activity staff were re-educated about the changes. The facility implemented a recreation attendance record to be completed each day to reflect attendance at group activities. In room visits are documented on the same form noting date and Resident. Element Two □ Identification of at Risk Residents All residents had the potential to be affected by the practice. Element Three □ Systemic Change An audit of the most recent APR for current Residents was completed by Certified Activity Directors and changes made as appropriate to reflect the current interests, abilities, and preferences of each Resident. The care plan of each Resident was reviewed and updated as	

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{F 679}	Continued From page 3 interventions/approaches have been effective in reaching goals. A review of the AR revealed that Resident #3 had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26. . The most recent MDS dated NJ Ex Order 26.4(b)(1), included but was not limited to; a BIMS of NJ Ex out of 15 indicative of NJ Ex Order 26.4(b)(1). The MDS did not include resident preferences. A review of the ICCP included a focus area initiated NJ Ex Order 26.4(b)(1) and revised on readmission NJ Ex Order 26.4(b)(1), enjoys activities such as NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1). A review of the quarterly APR dated NJ Ex Order 26.4(b)(1), included but was not limited to; includes a section to "describe the resident's attendance preferences and participation level with activities ... relevant NJ Ex Order 26.4(b)(1), ... new interests", spends time NJ Ex Order 26.4(b)(1), does not participate in activities. A review of the AR revealed that Resident #4 had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The quarterly MDS dated NJ Ex Order 26.4(b)(1), included but was not limited to; a BIMS of NJ Ex out of 15 which indicated NJ Ex Order 26.4(b)(1). The ICCP included a focus area dated NJ Ex Order 26. , needs NJ Ex Order 26.4(b)(1) to participate NJ Ex Order 26.4(b)(1). There was no previous activity care plan focus areas documented from the date of admission in NJ Ex Order 2 The annual APR dated NJ Ex Order 26.4(, included but was not limited to; includes a section to "describe the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with activities ... relevant NJ Ex Order 26.4(b)(1), ... new interests", resident spends most time NJ Ex Order 26. , was on NJ Ex Order 26.4(b)(1) which included NJ Ex Order 26. NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) The ADR further documented Focus(es) were current as per care	{F 679}	appropriate based on the APR and activity staff educated about any changes. Activities staff were re-educated about the recreation attendance record to be completed daily that reflects attendance at group programs and in-room visits. A Certified Activity Director (CAD) was hired and started on March 3, 2025. The new CAD is being mentored by sister facility CADs as needed. Element Four - QAPI The Activity Director/designee will audit resident group attendance and in-room visit records weekly x4 then monthly x2 ensuring proper compliance, results will be reported to the QAPI committee for review and action as necessary. Completion Date 3-5-2025	

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{F 679}	Continued From page 4 plan, goals were met, and interventions/approaches have been effective. A review of the AR indicated that Resident #5 had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) The quarterly MDS dated NJ Ex Order 26.4(, indicated Resident #5 had a BIMS of NJ Ex out of 15 indicating NJ Ex Order 26.4(b)(1). The ICCP included a focus area initiated NJ Ex Order 26.4(b) and revised NJ Ex Order 26 , spends their time NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Likes to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), enjoys NJ Ex Order 26.4(b)(1), and can NJ Ex Order 26.4(b)(1) to join NJ Ex Order 26.4(b)(1). The ICCP included an intervention revised NJ Ex Order 26.4(b) to continue to support wants and needs. The other two interventions had no initiated or revised dates. The quarterly APR dated NJ Ex Order 26.4(, included a section to "describe the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(... relevant NJ Ex Order 26.4(b)(1) , ... new interests" and documented resident spends most time NJ E and NJ Ex Order 26.4(b)(1 . Resident does NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b) what is going on. NJ Ex Order 26.4(b)(1) will continue to inform and NJ Ex Order 26.4(b)(1) resident to participate in more NJ Ex Order 26.4(b)(1) A review of the AR revealed that Resident #6 had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b) The quarterly MDS dated NJ Ex Order 26.4(b) documented a BIMS of NJ Ex out of 15 indicating NJ Ex Order 26.4(b)(1). The ICCP included a focus area dated NJ Ex Order 26.4 , resident prefers to spend the majority of the day NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) , likes to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1 Interventions initiated NJ Ex Order 26.4 included to continue to support	{F 679}		

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{F 679}	Continued From page 5	{F 679}		

the resident's wants and needs. Two other interventions which were not dated were to provide a NJ Ex Order 26.4(b)(1) and to motivate and encourage NJ Ex Order 26.4(b)(1) the resident NJ Ex Order 26.4(b)(1). The quarterly APR dated NJ Ex Order 26.4(b)(1), included a section to "describe the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) level with NJ Ex Order 26.4(b)(1) ... relevant NJ Ex Order 26.4(b)(1), ... new interests" documented the resident NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). The focus(es) document current as per care plan, goals were met, interventions effective in reaching goals.

A review of the AR revealed that Resident #7 had diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). The quarterly MDS dated NJ Ex Order 26.4(b)(1), documented a BIMS of NJ Ex Order 26.4(b)(1) out of 15 indicating NJ Ex Order 26.4(b)(1). The ICCP failed to include any focus area, goal, and interventions for NJ Ex Order 26.4(b)(1). The quarterly APR dated NJ Ex Order 26.4(b)(1), included "describe the resident's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) ... relevant NJ Ex Order 26.4(b)(1), ... new NJ Ex Order 26.4(b)(1) documented the resident NJ Ex Order 26.4(b)(1) to attend NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1)-Related Focus(es) and Preferences; goals; and interdisciplinary interventions/approaches were all left blank.

On 2/11/25 at 11:11 AM, both surveyors interviewed an U.S. FOIA (b) (6) that was identified by the facility U.S. FOIA (b) (6)) as helping with the activity program, but was employed full-time at another facility. The U.S. FOIA (b) (6) confirmed that she worked at another facility full-time, and she would come to the facility one to two days a week to supervise

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 _____	R 02/11/2025

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 679}	Continued From page 6 the U.S. FOIA (b) (6)), who was employed at the facility full time as the U.S. FOI and their signature in the electronic medical record was "nursing assistant", regarding the activity program. On 2/11/25 at 12:15 PM, the U.S. FO and the U.S. FOIA (b) (6 were the activities office, and the surveyor requested any documentation regarding monitoring resident participation and response to the activity programs and activities that were their assessed interests. The U.S. FOIA (b) (6 was unaware of what the surveyor was requesting and did not offer anything. The U.S. FO stated, "We have not gotten to that yet." Both the U.S. FO and U.S. FOIA (b) (6 acknowledged that was no process and no documentation that the facility assessed the residents for their response or attendance to any preferred activities. A review of the facility provided policy, "Activities" revised 12/24/24, included but was not limited to; the interdisciplinary care team will evaluate the ... history and preferences, and will consider medical conditions ... in identifying relevant recreational and cultural activities. A review of the facility provided, "Recreation Director" position title dated 11/18/24, included but was not limited to; documents the recreation program and the resident's progress ... maintains records to improve future planning, individualized approach and continual evaluation and revision; evaluates the effectiveness of the program in terms of enhancing the quality of the resident's life ... evaluations should be done quantitatively and qualitatively because the activity program is revised based on the results. Job skills ... perform record keeping and documentation as	{F 679}		

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{F 679}	Continued From page 7 necessary. On 2/11/25 at 1:20 PM, the U.S. FOIA (b) (6) [redacted] was in the conference room with two surveyors. The concerns were addressed. The [redacted] asked if it was a regulation to document resident participation and response. The [redacted] was instructed to review the regulations for guidance. NJAC 8:39-7.1(a); 7.3(g); 8.1	{F 679}		
{F 680} SS=F	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: NOT CORRECTED Based on observation, interview and review of	{F 680}	F680 Element One □ Corrective Actions	3/5/25

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{F 680}	Continued From page 8 pertinent facility documents, it was determined that the facility failed to ensure that qualified therapeutic recreation specialist directed the development, implementation, supervision and ongoing evaluation of the activities program. This deficient practice was identified for 5 of 5 residents whose activity assessment was completed by non-qualified staff, and had the potential to affect all residents who resided in the facility: On 2/11/25 at 8:56 AM, two surveyors entered the common area of the facility and observed the activities calendar. On 2/11/15 at 9:28 AM, the U.S. FOIA (b) (6) [redacted]) stated to the surveyors that she was enrolled in an online program for certification as an activity director and was still a U.S. FOIA (b) (6) [redacted]. She acknowledged that an U.S. FOIA (b) (6) [redacted] who worked at another facility would come to the facility one or two days a week. The U.S. FO[redacted] was working on teaching her how to do activity assessments, but the U.S. FOIA (b) (6) stated, "I can not sign off on those. I'm not certified." The surveyors reviewed the following electronic Medical Record (emir) which revealed: Resident #1 included a quarterly Activity Participation Review (APR) dated NJ Ex Order 26.4(b), which was signed by the U.S. FOIA (b) (6) and documented her title as U.S. FOIA (b) (6). There was no-co-signature on the document. A review of the eMR for Resident #2 included the quarterly APR dated NJ Ex Order 26.4(b)(1 which was signed by the U.S. FOIA (b) (6) and noted her title as U.S. FOIA (b) (6) [redacted]. There was no-co-signature on the document.	{F 680}	The facility hired a full-time U.S. FOIA (b) (6) [redacted]) who started employment on NJ Ex Order 26.4(b)(1) [redacted]. The facility had sister facility Certified Activity Directors review, revise as needed, and sign the most recent APR for each resident and then review and update the care plan as appropriate to ensure the assessment and care plan met the current interests, abilities, and preferences of each resident. Element Two □ Identification of at-risk Residents All residents had the potential to be affected by this practice Element Three □ Systemic Change All residents and facility staff were informed of the hiring of a Certified Activity Director and all activity staff were re-educated about their role and that of the CAD for completing the assessment and updating care plans. Element Four - QAPI A sister facility CAD/designee will monitor the new certified activity director□s performance through audits of 10% of APR assessments weekly for two weeks then monthly for two months to ensure they are properly completed and signed, and the care plan has been updated. Results will be reported to the QAPI committee for review and action as necessary Completion Date	

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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{F 680}	Continued From page 9 A review of the eMR for Resident #3 included the quarterly APR dated [redacted], which was signed by the [redacted] and noted her title as [redacted]. There was no-co-signature on the document. A review of the eMR for Resident #4 included an annual APR dated [redacted], which was signed by the [redacted] and noted her title as [redacted]. There was no-co-signature on the document. A review of the eMR for Resident #5 included had diagnoses which included the quarterly APR dated [redacted], which was signed by the [redacted] and noted her title as U.S. FOIA (b) (6). There was no-cosignature on the document. On 2/11/25 at 9:41 AM, the U.S. FOIA (b) (6) [redacted] was interviewed by both surveyors. The [redacted] stated that there was a U.S. FOIA (b) (6) [redacted]) who worked at another facility, one to two days a week, and the [redacted] "would email, and text with the [redacted] When asked how the [redacted] was supervised when the [redacted] was present, the [redacted] stated, "there are people under her [activities staff], but nobody was certified." On 2/11/25 at 10:00 AM, during a follow up interview, the surveyors inquired if there was any documentation of any of the training that the [redacted] stated was occurring, or any documented oversight of the [redacted] The [redacted] stated that the [redacted] completed things in "real time", and if anything was wrong, the [redacted] would let him know, but the [redacted] stated "nothing was documented." The [redacted] had no further information to provide. On 2/11/25 at 10:25 AM, the [redacted] was interviewed again. When asked if the unqualified	{F 680}	3-5-2025	

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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{F 680}	Continued From page 10 U.S. FOIA (b) (6) was able to complete and sign-off as the person who completed the activity assessments. The U.S. FOIA (b) (6) stated "he would have to get back to us", and provide no further documentation. On 2/11/25 at 11:11 AM, the U.S. FOIA (b) (6) arrived at the facility and in the presence of two surveyors, she confirmed that she was employed at another facility. When inquired about the activity assessments, she stated anyone could do an assessment, but only a U.S. FOIA (b) (6) was able to sign them. The U.S. FOIA (b) (6) explained she would need to sign the assessments because she had been through the certification course and knew how to judge the answers. When asked how it would be documented if a resident was receiving 1:1 room visits for activities. The U.S. FOIA (b) (6) stated that she would go "on faith" to determine if the staff completed the 1:1 room visits. The U.S. FOIA (b) (6) stated that 1:1 visits would be hard to document and no additional information to provide. When asked about the U.S. FOIA (b) (6) who signed the above mentioned activity assessments, the U.S. FOIA (b) (6) replied, "that was my mistake. I was not even thinking, and I may have let her sign." A review of the facility provided, "Recreation Director" signed 11/18/24, by the U.S. FOIA (b) (6) included but was not limited to; requirements ... certification in accordance with New Jersey regulation and an Associates degree in recreation was preferred. Accepts professional obligations ... for professional development ... by participating in basic and continuing education through professional organizations. On 2/11/25 at 1:20 PM, the U.S. FOIA (b) (6) was made aware of the concerns and had no additional	{F 680}		

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{F 680}	Continued From page 11 information to provide. NJAC 8:39-7.1(b)	{F 680}		

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	2/11/2025 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 F0550	Correction	ID Prefix F0584	Correction	ID Prefix F0677	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	02/11/2025	LSC	02/11/2025	LSC	02/11/2025
ID Prefix F0689	Correction	ID Prefix F0695	Correction	ID Prefix F0712	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.30(c)(1)-(4)	Completed
LSC	02/11/2025	LSC	02/11/2025	LSC	02/11/2025
ID Prefix F0838	Correction	ID Prefix F0847	Correction	ID Prefix F0880	Correction
Reg. # 483.71(a)(1)(3)(b)(1)(c)(1)-(5)	Completed	Reg. # 483.70(m)(1)(2)(i)(ii)(3)-(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/11/2025	LSC	02/11/2025	LSC	02/11/2025
ID Prefix F0921	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.90(i)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/11/2025	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 12/12/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ 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	3/6/2025 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 F0679 Reg. # 483.24(c)(1) LSC	Correction Completed 03/05/2025	ID Prefix F0680 Reg. # 483.24(c)(2)(i)(ii)(A)-(D) LSC	Correction Completed 03/05/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/12/2024	☐ 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 _____	**12/12/2024**

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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E 000	Initial Comments Rose Mountain Care Center 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		
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 12/03/24, 12/4/24 and 12/5/24, Rose Mountain Care Center 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. 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. There were 112 licensed beds with a census of 83.	K 000		
K 211 SS=E	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	K 211		12/25/24

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

Electronically Signed | 12/24/2024

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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K 211	Continued From page 1 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: Based on observation and interview on 12/03/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure exits were maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101:2012 Edition, Section 7.1.10.1. for 1 of 15 exits doors. This deficient practice had the potential to affect all 14 residents on West Wing and was evidenced by the following: Observations at approximately 11:15 AM, revealed the small dining room designated Exit door to exit discharge was blocked with chair. In an interview at the time, the [redacted] confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at the Life Safety Code survey exit conference on 12/05/2024 at 2:45 PM. N.J.A.C 8:39-31.2(e)	K 211	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K211 (E) Means of Egress Element One: The chair blocking the designated exit door was immediately removed and the door was left free of obstructions. Element Two: This deficient practice had the potential to affect all residents. Element Three: The U.S. FOIA (b) (6) [redacted] was educated on the requirements regarding means of egress is continuously maintained free of all obstructions to full use in case of emergency Element Four: The Maintenance Director / designee will audit the Designated exit doors to continue to be free of obstructions weekly	

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K 211	Continued From page 2	K 211	x4 then monthly x2. Findings to be reported to the QAPI team for review Completion Date: 12-25-2024	
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler	K 222		12/25/24

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 _____	12/12/2024

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
K 222	Continued From page 3 and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/04/24 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to provide 2 of 15 exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient	K 222	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K222 - F Egress Doors Element One:	

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K 222	Continued From page 4 practice had the potential to affect all 83 residents and was evidenced by the following: Observations at approximately 8:54 AM, revealed the Kitchen designated Exit door to the exit discharge was equipped with a sliding bolt lock on the egress side of the door. The fastening device on the door was engaged and could restrict emergency use of the designated exit discharge door. An observation at 11:35 AM in the presence of the [redacted], revealed the exit door located in the facility's Main dining room to the Courtyard had a keyed lockset on the egress side. The device on the door could restrict emergency use of the exit. The [redacted] tested the doors by locking and pushed to open, but he could not open the door. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] was notified of the deficient practice at the Life Safety Code survey exit conference on 12/05/2024 at 2:45 PM. N.J.A.C. 8:39-31.2(e)	K 222	The lock from the dining room door to the courtyard was immediately removed and a passage way door lock was installed. The sliding bolt lock on the kitchen exit door was immediately removed Element Two: This deficient practice had the potential to affect all residents Element Three: The [redacted] was educated on ensuring designated exit / Egress doors are readily accessible and free of all obstructions or impediments. Element Four: The Maintenance Director / designee will audit the courtyard and kitchen exit doors to ensure the exit access remains readily accessible and free of all obstructions or impediments monthly x3. Results to be reported to the QAPI team for review Completion Date: 12-25-2024	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release	K 223		12/25/24

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K 223	Continued From page 5 device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/04/24 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that self-closing door to hazardous area was capable of automatically closing upon the activation of the facility's fire alarm system. This deficient practice had the potential to affect limited residents in the area and was evidenced by the following: At 9:30 AM, the surveyor observed the door to laundry dryer room was held open with a rope tied around the door handle to a storage rack behind door. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 12/05/2024 at 2:45 PM. NJAC 8:39-31.2(e)	K 223	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K223 - (D) Doors with self closing Devices Element One: The rope tied around the door handle that held the laundry / dryer room open was immediately cut and removed Element Two: This deficient practice had the potential to affect limited residents in the area. Element Three: The U.S. FOIA (b) (6) as well as the laundry staff were educated on the requirements regarding self automatic closing doors. Element Four: The Maintenance director will audit the laundry / dryer room door weekly x4 then	

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K 223	Continued From page 6	K 223	monthly x2 to ensure proper automatic and self closing. Results will be reported to the QAPI team for review Completion Date: 12-25-2024	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/3/2024 in the presence U.S. FOIA (b)(6) [redacted]), it was determined that the facility failed to provide illumination for the means of egress that was either continuously in operation or capable of automatic operation without manual intervention in accordance with NFPA 101: 2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all 83 residents and was evidence by the following: 1. An observation at approximately 9:20 AM, revealed Kitchen corridor was over 27-feet long to the Exit door had no lighting when the switch was in the OFF position. 2. Observations at approximately 10:07 AM, revealed East Hall had no lighting when the switch was in the OFF position.	K 281	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K281 - (F) Illumination of means of Egress Element One: The lights in the kitchen corridor were immediately repaired to have continued lighting while the switch is in the OFF position The lights in the East wing hall were immediately repaired to have continued lighting while the switch is in the OFF position	12/25/24

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K 281	Continued From page 7 3. Observations at approximately 1:17 PM, revealed West Hall had no lighting when the switch was in the OFF position. In an interview at the time, the [U.S. FOIA] confirmed the observations. The facility's [U.S. FOIA (b)(6)] were notified of the deficient practice at Life Safety Code survey exit conference on 12/05/2024 at 2:45 PM. N.J.A.C 8:39-31.2(e)	K 281	The lights in the West wing hall were immediately repaired to have continued lighting while the switch is in the OFF position Element Two: This deficient practice had the potential to affect all residents Element Three: The [U.S. FOIA (b) (6)] was educated on the requirements for continuous lighting even while the light switch is in the OFF position Element Four: The Maintenance director / designee will audit the West wing, East wing and the Kitchen corridors to ensure there is continuous lighting even while the light switch is in the OFF position monthly x3. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1	K 293		12/25/24

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K 293	Continued From page 8 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/04/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure exit and directional exit signs were provided and marked by approved, readily visible signs in all cases where the exit or way to reach the exit was not readily apparent to the occupants in accordance with NFPA 101: 2012 Edition, Sections 19.2.10.1 and 7.10. This deficient practice had the potential to affect approximately 18 residents and was evidenced by the following: An observation at 8:59 AM, revealed the Kitchen exit access was not provided with an exit or directional sign. In an interview at the time, the [redacted] confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 12/05/2024 at 2:45 PM. NJAC 8:39-31.1 (c), 31.2(e)	K 293	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K293 - E Exit Signage Element One: An exit sign was immediately installed at the kitchen back exit access Element Two: This deficient practice had the potential to affect approximately 18 residents Element Three: The U.S. FOIA (b) (6) was educated on the the requirements regarding proper exit signage Element Four: The maintenance director / designee will audit the exit sign at that location monthly x3 ensuring its properly functioning. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	

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K 321	Continued From page 9	K 321		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 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 observations and interview on 11/03/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012	K 321	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024	12/25/24

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K 321	Continued From page 10 Edition, Sections 19.3.2, 19.3.2.1.3, 8.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect all 83 residents and was evidenced by the following: Observations with the U.S. FOIA from 8:15 AM and 3:45 PM, revealed East and West wing shower rooms were over 55 square feet and were being used to store combustibles. The doors to these rooms were not provided with a self-closing device. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 12/05/2024 at 2:45 PM. N.J.A.C 8:39-31.2(e) NFPA 80	K 321	K321 - F Hazardous Areas - Enclosure Element One: A self closing device was immediately installed at the East and West wing shower rooms to protect the hazardous areas Element Two: This deficient practice had the potential to affect all residents Element Three: The U.S. FOIA (b) (6) was educated on the requirements regarding self closing doors for hazardous areas Element Four: The Maintenance director / designee will audit the self closing doors monthly x3 ensuring its properly functioning. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		12/25/24

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K 324	Continued From page 11 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/04/24 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure 5 of 5 kitchen hood suppression systems spray nozzle caps were in place to protect the nozzles from grease clogs in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 17 and 96. This deficient practice had the potential to affect all 83 residents and was evidenced by the following: Observations in the kitchen at 9:08 AM, revealed 5 of 5 kitchen nozzle blow-off caps were not in place to protect the spray nozzles from being clogged from grease build up.	K 324	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K324 - F Cooking Facilities Element One: Our vendor was immediately called in for service, upon arrival they confirmed that there are in fact all 5 nozzle caps in place to protect from grease clogs. It is placed under the metal inside the nozzles (unlike the Ansul systems that have the orange visible caps.)	

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K 324	Continued From page 12 In an interview, the U.S. FOIA confirmed and acknowledged the findings. The U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 12/05/24 at 2:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 10, 96	K 324	Element Two: This deficient practice had the potential to affect all residents Element Three: The U.S. FOIA (b) (6) was educated on the requirements regarding spray nozzle caps being in place to protect the nozzles from grease clogs. All 5 spray nozzle caps have been confirmed to be in place. Element Four: The Maintenance director / designee will audit the kitchen suppression system spray nozzle caps monthly x3 ensuring its in place and properly functioning. Results will be reported to the QAPI team for review Completion Date: 12-25-2024	
K 342 SS=F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be	K 342		12/25/24

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K 342	Continued From page 13 required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/04/24 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure fire alarm manual pull stations were always accessible in accordance with NFPA 72:2010 Edition, section 17.14.5. This deficient practice had the potential to affect all 83 residents and was evidence by the following: At 11:55 AM, the surveyor observed the manual fire alarm pull station in the small dining room by the exit door was blocked with dining table. At 12:07 PM, the surveyor observed the manual fire alarm pull station in Physical therapy room by the exit door was blocked with four wheelchairs and Physical therapy bed. In an interview at the time, the U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b)(6) were notified of the deficient practice at Life Safety Code survey exit conference on 12/05/2024 at 2:45 PM. NJAC 8:39-31.2(e) NFPA 72	K 342	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K342 - (F) Fire Alarm System - Initiation Element One: The dining table blocking the fire alarm pull station at the exit door in the small dining room was immediately removed. The four wheelchairs and the Physical therapy bed blocking the fire alarm pull station in the Physical therapy room by the exit door were immediately removed. Element Two: This deficient practice had the potential to affect all residents Element Three: The U.S. FOIA (b) (6) was educated on the requirements regarding the fire alarm manual pull stations are always accessible without obstruction. All staff	

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K 342	Continued From page 14	K 342	were trained and educated on the above topic as well as to report findings asap. Element Four: The Maintenance director / designee will audit the above mentioned fire alarm pull stations monthly x3 ensuring they remain accessible without obstruction. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		12/25/24

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K 353	Continued From page 15 by: Based on observations, documentation review and interview on 12/4/2024 and 12/5/2024 in the presence U.S. FOIA (b)(6)), it was determined that the facility failed to maintain the fire sprinkler heads and failed to ensure that the fire sprinkler system back flow preventer annual test was conducted in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25: 2011 Edition, Section 13.6.2.1. This deficient practice had the potential to affect all 83 residents and was evidenced by the following: Observations on 12/03/24 from 8:45 AM to 3:45 PM revealed: At 9:08 AM, five of 8 kitchen fire sprinkler heads were green with a coating of oxidation At 9:25 AM, three of 6 Laundry fire sprinkler heads were green with a coating of oxidation and covered with lint. A documentation review on 12/05/24 at 8:31 AM, revealed no records on fire sprinkler system back flow preventer test inspections were provided. In an interview, the U.S. FOIA confirmed and acknowledged the findings. The U.S. FOIA (b)(6) was informed of the deficient practices at the Life Safety Code exit conference on 12/05/24 at 2:45 PM. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 25	K 353	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K353 - (F) Sprinkler System - Maintenance and Testing Element One: The sprinkler heads in the kitchen and in the laundry area that were found to be green with a coating of oxidation and covered with lint were all replaced. The facility immediately reached out to our vendor to conduct the fire sprinkler system back flow preventer test. Element Two: This deficient practice had the potential to affect all residents Element Three: The sprinkler heads in the kitchen and in the laundry area that were found to be green with a coating of oxidation were all replaced. The U.S. FOIA (b) (6) was educated on the requirements related to maintaining the sprinkler heads as well as the annual back flow test requirements. Element Four: The maintenance director will audit all the fire sprinkler heads in the laundry and kitchen areas ensuring proper function	

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 _____	**12/12/2024**

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 353	Continued From page 16	K 353	and maintenance monthly x3. The maintenance director will also conduct a walkthrough of the facility sprinkler heads for visual corrosion. The maintenance director will also monitor and take necessary measures on all the sprinkler reports. Results will be reported to the QAPI team for review Completion Date: 12-25-2024	
K 362 SS=E	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and interview on	K 362	Rose Mountain Care Center	12/25/24

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 _____	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 362	Continued From page 17 12/4/2024 in the presence U.S. FOIA (b)(6) it was determined that the facility failed to ensure that the corridor walls were constructed to resist the passage of smoke in accordance with NFPA 101: 2012 Edition, Section 19.3.6.2 and 19.3.2.7. This deficient practice had the potential to affect all East Wing residents and was evidenced by the following: An observation at 9:41 AM with the U.S. FOIA revealed a hole in the wall above the laundry corridor door in the ceiling. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 12/5/24 at 2:45 PM. N.J.A.C. 8:39-31.2(e)	K 362	Facility ID: 3145384 Survey completion date 12-12-2024 K362 - E Corridors - Construction of Walls Element One: The hole in the wall above the laundry corridor door in the ceiling was immediately sealed Element Two: This deficient practice had the potential to affect all East Wing residents Element Three: The U.S. FOIA (b) (6) was educated on the requirements related to ensuring the corridor walls are constructed to resist the passage of smoke Element Four: The Maintenance director / designee will audit the above findings monthly x3 to ensure the hole remains sealed and passage of smoke is resisted. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	
K 363 SS=F	Corridor - Doors	K 363		12/25/24

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 _____	**12/12/2024**

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K 363	Continued From page 18 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 protection ratings, automatics closing devices,	K 363		

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K 363	Continued From page 19 etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 12/4/2024 in the presence U.S. FOIA (b)(6) 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 Edition, Sections 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect all 83 residents and was evidenced by the following: During the tour from 8:15 AM to 3:45 PM, the surveyor and U.S. FOIA observed the following: 1. The double doors between the West wing and the Main dining room had a gap between the meeting edges when tested by U.S. FOIA. 2. The room #9 door had a gap on top when tested by the U.S. FOIA D In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code Survey exit conference on 12/05/2024 at 2:45 PM. NJAC 8:39-31.1(c), 31.2(e)	K 363	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K363 - (F) Corridor - Doors Element One: The gap on the double doors between the west wing and the dining room was immediately sealed leaving no room for smoke to pass through. The gap on door room #9 was immediately sealed. Element Two: This deficient practice had the potential to affect all 83 residents Element Three: The U.S. FOIA (b) (6) was educated on the requirements related to corridor doors resisting the passage of smoke Element Four: The maintenance director / designee will audit the above findings monthly x3 ensuring the doors are able to resist the passage of smoke. Results will be reported to the QAPI team for review.	

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K 363	Continued From page 20	K 363		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 12/04/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to conduct fire drills with varying activation types in accordance with NFPA 101: 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 12 of 12 fire drills, had the potential to affect all 83 residents and was evidenced by the following: A review of the facility's fire drill reports at 1:38 PM revealed that records provided for 12 of 12 months had no indication the fire drills were conducted with an activation or the type of alarm transmission signal: Pull, Smoke or Page. The findings were verified by the [redacted] at the time of record review. The [redacted] confirmed that the fire	K 712	Completion Date: 12-25-2024 Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K712 - (F) Fire Drills Element One: The facility immediately modified the fire drill reports to include the type of device used to activate the fire alarm system. (pull, page, and smoke). Element Two: This deficient practice had the potential to affect all residents	12/25/24

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K 712	Continued From page 21 drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page, and smoke). The facility's U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 12/5/2024 at 2:45 PM. NJAC 8:39-31.2(e)	K 712	Element Three: The U.S. FOIA (b) (6) was educated on the requirements related to conducting fire drills with varying activation types. Element Four: The maintenance director / designee will audit the newly modified fire drill reports ensuring they are being followed through with an indication of an activation type monthly x3. Results will be reported to the QAPI team for review. Completion Date: 12-25-2024	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment	K 921		12/25/24

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K 921	Continued From page 22 instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 12/03/2024, 12/04/2024 and 12/05/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. This deficient practice had the potential to affect all 83 residents and was evidenced by the following: Observations on 12/03/2024 from 8:15 AM to 3:45 PM revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility. In an interview at the time, the U.S. FOIA confirmed the findings. A documentation review on 12/05/2024 revealed no policy on patient care related electrical	K 921	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K921 - (F) Electrical Equipment - Testing and Maintenance Element One: The Maintenance director immediately conducted maintenance on the electrical equipment, as well as logging the inspection and the repairs if necessary. The facility immediately implemented a policy related to patient care related electrical equipment ensuring inspections annually and as needed. Element Two: This deficient practice had the potential to affect all residents	

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K 921	Continued From page 23 equipment was provided. In an interview at that time, the U.S. FOIA and confirmed the findings and acknowledged that there was no policy. The facility's U.S. FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 12/5/2024 at 2:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 921	Element Three: The U.S. FOIA (b) (6) was educated on the requirements related to K921 PCREE Including conducting maintenance of electrical equipment and maintaining a record and log of all required tests and repairs if necessary. Element Four: The maintenance director / designee will audit the patients equipment ensuring the policy is being followed through monthly x3. (policy including annual inpections and as needed, new admisions, new equipment) Results will be reported to the QAPI team for review Completion Date: 12-25-2024	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of	K 923		12/25/24

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K 923	Continued From page 24 noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/4/2024 in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that empty portable oxygen cylinder tanks were separated from full portable oxygen cylinder tanks in accordance NFPA 101: 2012 Edition, Section 19.3.2.4,8.7 and NFPA 99. This deficient practice had the potential to affect all 31 residents on east wing and was evidenced by the following: An observation at 11:43 AM in the facility's oxygen storage closet, revealed 5 of 20 full	K 923	Rose Mountain Care Center Facility ID: 3145384 Survey completion date 12-12-2024 K923 - (E) Gas Equipment - Cylinder and Container Storage Element One: The 5 full portable oxygen cylinder tanks were immediately removed from the Empty tanks rack in the oxygen storage closet	

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K 923	Continued From page 25 portable oxygen cylinder tanks were in a storage rack with sign indicating Empty Tanks Only. In an interview at the time, the U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference on 12/5/2024 at 2:45 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 923	Element Two: This deficient practice had the potential to affect all 31 residents on east wing Element Three: The U.S. FOIA (b) (6) was educated on the requirements regarding empty portable oxygen cylinder tanks are separated from full portable oxygen cylinder tanks Element Four: The maintenance director / designee will audit the oxygen tanks ensuring they are kept separate monthly x3. Results will be reported to the QAPI team for review Completion Date: 12-25-2024	

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	2/21/2025 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	12/25/2024	LSC K0222	12/25/2024	LSC K0223	12/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	12/25/2024	LSC K0293	12/25/2024	LSC K0321	12/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	12/25/2024	LSC K0342	12/25/2024	LSC K0353	12/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0362	12/25/2024	LSC K0363	12/25/2024	LSC K0712	12/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0921	12/25/2024	LSC K0923	12/25/2024	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	
12/12/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO