

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 47a002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/23/2025
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NAME OF PROVIDER OR SUPPLIER ROSE HILL ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 WASHINGTON BLVD ROBBINSVILLE, NJ 08691
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>Complaint #: NJ 00189412</p> <p>Date of Survey: 12/23/25</p> <p>CENSUS: 37</p> <p>SAMPLE SIZE: 3</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs.</p> <p>The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

01/20/26

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189412</p> <p>Based on interview and record review, it was determined that the Administrator failed to ensure the implementation and enforcement of the facility policy titled, "Abuse and Neglect: Identifying and Reporting" for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>1. On 12/23/25 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility in [redacted] of [redacted] with diagnoses of NJ Exec Order 26.4b1 and history of [redacted].</p> <p>Further surveyor review of Resident #1's progress notes revealed that on [redacted] at 11:43 a.m., a Licensed Practical Nurse documented that a [redacted] was observed on Resident #1's [redacted] and NJ Exec Order 26.4b1</p> <p>At 2:32 p.m., the surveyor interviewed the Administrator and inquired about the [redacted] documented on Resident #1 on [redacted]. The Administrator stated that she was not aware of the [redacted] observed on Resident #1 on [redacted]. Additionally, the Administrator stated that an investigation was not conducted because she</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>was not aware of the [redacted] on Resident #1.</p> <p>2. Further surveyor review of Resident #1's progress notes written by the facility's previous Director of Health and Wellness (DOW) dated [redacted] at 2:25 p.m., for [redacted] documented that the resident was noted with [redacted] on the [redacted] and [redacted] NJ Exec Order 26.4b1." However, the surveyor did not observe any documented evidence that the RP was notified of the [redacted] discovered on [redacted].</p> <p>At 2:32 p.m., the surveyor interviewed the Administrator and inquired about the [redacted] of [redacted] documented on Resident #1 on [redacted]. The Administrator stated that she was not aware of the [redacted] observed on Resident #1 on [redacted]. The Administrator confirmed that Resident #1's RP was not notified of the [redacted] observed on the resident's [redacted] and [redacted].</p> <p>The surveyor reviewed the facility policy and procedure titled, "Abuse and Neglect: Identifying and Reporting" dated 11/10/25, which revealed, "... D. REPORTING 1. Report incident as soon as possible to the supervisor..."</p> <p>The surveyor reviewed the facility policy and procedure with a review date of 11/10/2025, titled, "Abuse and Neglect: Identifying and Reporting " which revealed that " ... D. REPORTING ... 2. The Supervisor/RN will: ... Notify the resident/patient representative ..."</p> <p>The surveyor reviewed the facility policy and procedure with a review date of 11/10/2025, titled, "Abuse and Neglect: Identifying and Reporting " which revealed that " ... D. REPORTING ... 2. The Supervisor/RN will: ... Notify the Attending</p>	A 310		
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A 310	Continued From page 3 Physician(s)..." Refer to 8:36-5.15(b) [A0615], 8:36-7.5(d) [A0781]	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 0189412, NJ 00189551 Based on interview and record review, it was determined that the facility failed to ensure a safe environment while providing care and services to residents for 1 of 3 residents, Resident #1. This deficient practice is evidenced by the following: The Department of Health (DOH) received a Facility Reportable Event (FRE), (a document used by facilities to report events to DOH) on [redacted] NJ Exec Order 26. According to the FRE, on [redacted] NJ Exec Order 26, a [redacted] NJ Exec Order 26, aide was [redacted] NJ Exec Order 26, Resident #1 to provide	A 401		

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A 401	<p>Continued From page 4</p> <p>care when the resident's [redacted] the [redacted] of the bed. Resident #1 was sent to the Emergency Room (ER) and was diagnosed with [redacted] / [redacted] and [redacted]</p> <p>On 12/23/25 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility in [redacted], with diagnoses of [redacted], history of a [redacted] and [redacted]</p> <p>Additionally, the surveyor reviewed a Progress Note (PN) written by a Licensed Practical Nurse (LPN), which documented that on [redacted] the LPN was notified by Resident #1's [redacted] that while providing personal care, Resident #1 [redacted] his/her [redacted] on the [redacted] of the bed. According to the PN, Resident #1 was sent to the ER for evaluation.</p> <p>Further surveyor review of the hospital discharge summary record provided by the Director of Wellness (DOW) dated [redacted], revealed that the resident was admitted to the hospital after a [redacted] that resulted in a [redacted], a [redacted] on the [redacted] and [redacted]</p> <p>At 2:52 p.m., the surveyor interviewed the DOW and inquired about Resident #1's [redacted] and [redacted] on [redacted]. The DOW stated that she was notified of Resident #1 [redacted] his/her [redacted] on the [redacted] during morning care and she (DOW) instructed the LPN to send the resident to the ER for evaluation. Additionally, the DOW stated that she was made aware of Resident #1's [redacted] on [redacted] when she called the hospital to check on the status of Resident #1.</p>	A 401		

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A 401	<p>Continued From page 5</p> <p>During continued surveyor interview, the DOW stated that she was not aware of any ^{NJ Exec Order 26.4b1} or how the ^{NJ Exec Order 26.4b1} occurred. The DOW explained that the resident had a history of ^{NJ Exec Order 26.4b1} prior to the resident's admission to the facility.</p> <p>The surveyor reviewed the facility policy and procedure with a review date of 11/10/25, titled, "Resident Handbook" which revealed, "... RESIDENT RIGHTS ... 22. The right to live in safe ... conditions in a facility ..."</p>	A 401		
A 615	<p>8:36-5.15(b) Notification Requirements</p> <p>(b) Notification of any occurrence noted in (a) above shall be documented in the resident's record.</p> <p>The documentation with regard to an occurrence noted in (a)4 above shall include confirmation and written documentation of that notification.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189412</p> <p>Based on interview and record review, it was determined that the facility failed to notify the Responsible Party (RP) of ^{NJ Exec Order 26.4b1} discovered on a resident for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 12/23/25 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility in ^{NJ Exec Order 26.4b1}, with diagnosis of</p>	A 615		

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A 615	<p>Continued From page 6</p> <p>NJ Exec Order 26.4b1.</p> <p>Further surveyor review of Resident #1's progress notes written by the facility's previous Director of Health and Wellness (DOW) dated NJ Exec Order 26 at 2:25 p.m., for NJ Exec Order 26 documented that the resident was noted with NJ Exec Order 26 on the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1." However, the surveyor did not observe any documented evidence that the RP was notified of the NJ Exec Order 26 discovered on NJ Exec Order 26.4b.</p> <p>At 2:32 p.m., the surveyor interviewed the Administrator and inquired about the NJ Exec Order 26.4b1 documented on Resident #1 on NJ Exec Order 26.4b. The Administrator stated that she was not aware of the NJ Exec Order 26 observed on Resident #1 on NJ Exec Order 26. The Administrator confirmed that Resident #1's RP was not notified of the NJ Exec Order 26 observed on the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the facility policy and procedure with a review date of 11/10/2025, titled, "Abuse and Neglect: Identifying and Reporting " which revealed that " ... D. REPORTING ... 2. The Supervisor/RN will: ... Notify the resident/patient representative ..."</p>	A 615		
A 753	<p>8:36-7.3(c) General and Health Service Plans</p> <p>(c) Documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan.</p>	A 753		

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A 753	<p>Continued From page 7</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189412</p> <p>Based on interview and record review, it was determined that the facility failed to develop and/or revise the service plan for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 12/23/25 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility in NJ Exec Order 26.4b1, with diagnoses of NJ Exec Order 26.4b1 and a history of a NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed the hospital discharge summary record provided by the Director of Wellness (DOW) dated NJ Exec Order 26.4b1 and observed that NJ Exec Order 26.4b1 recommended the following for Resident #1: NJ Exec Order 26.4b1, continue NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p> <p>At 2:52 p.m., the surveyor interviewed the DOW and inquired about Resident #1's SP. The DOW stated that the SP was updated following Resident #1's incident on NJ Exec Order 26.4b1. However, surveyor review of the SP provided by the DOW did not have documented evidence to show that the SP was updated to reflect the NJ Exec Order 26.4b1 as NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.</p>	A 753		

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A 781 A 781	<p>Continued From page 8</p> <p>8:36-7.5(d) Provision of Health Care Services</p> <p>(d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00189412</p> <p>Based on interview and record review, it was determined that the facility failed to notify the physician of [redacted] observed on a resident for 1 of 3 residents, Resident #1. This deficient practice was evidenced by the following:</p> <p>On 12/23/25 at 10:45 a.m., the surveyor reviewed Resident #1's medical record (MR), which revealed that Resident #1 was admitted to the facility in [redacted] with diagnosis of [redacted].</p> <p>Further surveyor review of Resident #1's progress notes written by the facility's previous Director of Wellness (DOW) dated [redacted] at 2:25 p.m., for [redacted] documented that the resident was noted with [redacted] on the [redacted] and [redacted]. However, the surveyor did not observe any documented evidence that the resident's physician was notified of the [redacted] observed on the resident on [redacted].</p>	A 781 A 781		

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A 781	<p>Continued From page 9</p> <p>At 2:32 p.m., the surveyor interviewed the Administrator and inquired about the [redacted] documented on Resident #1 on [redacted]. The Administrator stated that she was not notified of the [redacted] observed on Resident #1 on [redacted]. Additionally, the Administrator confirmed that Resident #1's physician was not notified of the [redacted] incident of [redacted] to the resident's [redacted] and [redacted].</p> <p>The surveyor reviewed the facility policy and procedure with a review date of 11/10/2025, titled, "Abuse and Neglect: Identifying and Reporting " which revealed that " ... D. REPORTING ... 2. The Supervisor/RN will: ... Notify the Attending Physician(s)..."</p>	A 781		
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POC #3 Rec'd 1/28/26.
Acceptable POC letter sent
2/2/26.



ROSE HILL

AN INSPIRIT
SENIOR LIVING
COMMUNITY

1150 WASHINGTON BLVD.
ROBBINSVILLE TWP, NJ
609-371-7007

ROSE HILL ASSISTED LIVING – PLAN OF CORRECTION

Survey Date: 12/23/2025
Facility: Rose Hill Assisted Living

A310 – 8:36-3.4(a)(1) Administrator’s Responsibilities

I. Corrective Action

Accepted
2/2/26

- Executive Director or designee will ensure the development, implementation and enforcement of all policies and procedures, including resident rights.
- I. Corrective Action

Element 1 Resident #1 was affected by the deficient practice. The resident was immediately transferred to the hospital. The [redacted]aker wa [redacted] from the facility. The facility immediately in-serviced all nursing employees. The [redacted] or resident #1 was [redacted] for when the resident returns. The facility started an audit on all [redacted] which consist of a list of residents, their [redacted] obtained Physician orders for all hospital [redacted] types. The facility also obtained signed consent forms for all [redacted]

II. How to Identify Other Residents

- All residents with side rails have the potential to be affected.

III. Systemic Changes

- The facility will monitor the measures or systemic changes by maintaining the audit that we created to keep it updated as the changes occur for new admissions, re-admissions, hospice, discharges and any new bed orders. The facility also padded resident #1 siderail (HALO).
- The Administrator, Director of Wellness (DOW) or designee will re-educate applicable staff on the facility policy: “Abuse and Neglect: Identifying and Reporting”, to include but not limited to:
 - Reporting incident as soon as possible to supervisor.
 - Notification to responsible party.
 - Notification to attending physician
 - Required reporting, escalation, and notification for bruising/unknown injury.

NJ Exec Order 26.4b1

Executive Director



- Element #4. The day of the deficient practice which occurred [redacted] the staff was immediately in-serviced and will be in-serviced monthly. Re-education will be provided monthly during the nursing staff meetings by the Director of Wellness, which will include Abuse & Neglect, Identifying and reporting, notification to Physician, and responsible party. It will also include required reporting, escalation, and notification of any injuries of unknown origin.

V. Completion Date

Element # V Completion date 03/23/2026

A401 – 8:36-4.1(a)(22) Resident Rights (Safe Environment)

I. Corrective Action

[redacted] Accepted
2/2/26

- The Executive Director will ensure that all residents have the right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care.
- Resident # 1 was affected by the unsafe practice.

II. How to Identify Other Residents

- All residents with side rails have the potential to be affected.

DOW/designee will identify residents requiring extensive assistance with bed mobility and ensure care approaches are clearly communicated and followed

III. Systemic changes

- Safety expectations reinforced through ongoing training and routine supervisory rounds.
- Staff re-educated on ensuring resident safety during care, including safe positioning/turning and ensuring bed/rail setup does not place residents at risk.

IV. Monitoring Process

- DOW/Designee will conduct these observations of personal care provided to ensure compliance with safe care expectations.
- Frequency: weekly X 4 weeks then monthly X 2 months
- The Executive Director will monitor to ensure compliance.

V. Completion Date – 03/23/26



A615 – 8:36-5.15(b) Notification Requirements

Accepted
3/2/26

I. Corrective Action

- Executive Director will ensure that responsible party will be notified of any occurrence noted in the resident's record. Notification shall include confirmation and written documentation of that notification in the resident's record.

II. How to Identify Other Residents

- DOW/designee will complete a **look-back review** of documentation for bruising/injury occurrences for the past 90 days to ensure responsible party notifications are completed and documented.

III. Systemic Changes

- Licensed nurses re-educated on the requirement to notify the Responsible Party of occurrences and to document notification in the record per regulation.

IV. Monitoring Process

- Audit of resident records for evidence of:
 - RP notification
 - date/time and method of notification documented
- Frequency: weekly X 4 weeks the monthly X 2 months
- Executive Director will monitor to ensure compliance.
-
-

V. Completion Date

03/23/2026



A753 – 8:36-7.3(c) General and Health Service Plans

I. Corrective Action

NJ Exec Order 21
Accepted
2/2/24

Resident #1 was affected by this deficient practice.

- The Director of Wellness DOW will ensure that documentation in the resident's record shall indicate review and any necessary revision of the resident service plan and/or health service plan. The Executive Director will monitor for compliance.

II. How to Identify Other Residents

All residents discharged from the hospital would be affected.

- DOW/designee will complete a **look-back review** for all residents discharged from the hospital for the past 90 days to verify service plans reflect discharge recommendations, as needed.

III. Systemic Changes

- DOW/designee will audit hospital return packets and service plan updates to confirm revision is completed timely.
- Frequency: weekly.
- Executive Director will monitor for compliance.

III. Monitoring Process

- DOW/designee will audit hospital return packets and service plan updates to confirm revision is completed timely.
- Frequency: weekly.
- Executive Director will monitor for compliance.

V. Completion Date

03/23/2026



A781 – 8:36-7.5(d) Provision of Health Care Services (Physician Notification)

NJ Exec Order 26
Accepted
2/2/26

I. Corrective Action

- Resident # 1 was affected by the deficient practice.
- The Director of wellness will ensure that resident's healthcare provider, shall be notified by the licensed professional nurse of any NJ Exec Order 26.4b1 in the resident's physical or
- cognitive/mental condition and any intervention by the physician shall be recorded. The Executive Director monitor for compliance.

II. How to Identify Other Residents

- All residents have the potential to be affected by the deficient practice.
- DOW/designee will complete a **look-back review** for the last 90 days to identify recent bruising/injury documentation to verify healthcare provider notification was completed and recorded.

III. Systemic Change

- Licensed nursing staff re-educated on physician notification requirements for significant changes including bruising/unknown injury and documentation of physician notification.

IV. Monitoring Process

- Audit of:
 - progress notes
 - incident reports
 - physician contact documentation
- Frequency: weekly.
- Executive Director will monitor to ensure compliance.

V. Completion Date

03/23/2026

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 47a002	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/2/2026
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NAME OF FACILITY ROSE HILL ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 WASHINGTON BLVD ROBBINSVILLE, NJ 08691
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This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0615	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.15(b)	Completed
LSC	03/23/2026	LSC	03/23/2026	LSC	03/23/2026
ID Prefix A0753	Correction	ID Prefix A0781	Correction	ID Prefix	Correction
Reg. # 8:36-7.3(c)	Completed	Reg. # 8:36-7.5(d)	Completed	Reg. #	Completed
LSC	03/23/2026	LSC	03/23/2026	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
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FOLLOWUP TO SURVEY COMPLETED ON 12/23/2025	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 47a002	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/2/2026
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LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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