| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315421 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 10/31/2025 |
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| ROSE GARDEN NURSING AND REHABILITATION CENTER | 1579 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753 |

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| F0000 | INITIAL COMMENTS<br><br>Complaint #: NJ 2561976<br><br>Survey Date: 10/31/25<br><br>Census: 113<br><br>Sample: 3<br><br>A Complaint Survey was conducted at Rose Garden Nursing and Rehabilitation Center on 10/31/25 to determine compliance with 42 CFR Part 483, requirements for Long Term Care Facilities.<br><br>During the survey a finding which constituted an IJ was identified under 42 CFR 483.60(d)(4) F600 as the facility failed to ensure that a resident, (Resident #1), who was NJ Ex Order 26.4(b)(1) and required assistance for NJ Ex Order 26.4(b)(1) was protected from NJ Ex Order 26.4(b)(1) when they were NJ Ex Order 26.4(b)(1) approximately 12:50 PM until approximately 3:30 PM on NJ Ex Order 26.4(b)(1) ( NJ Ex Order 26.4(b)(1) ).<br><br>On 7/3/25 at approximately 12:50 PM, a Certified Nursing Assistant (CNA #1) transported Resident #1 (who was NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26.4(b)(1) , in a wheelchair to the NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 . CNA #1 did not communicate to other facility staff that Resident #1 was NJ Exec Order 26.4b1 Resident #1's assigned CNA (CNA #2) nor did any other staff did not check on the resident from 12:20 PM through the end of her shift which was 3:00 PM.<br><br>At approximately 3:20 PM, Resident #2 and a visitor were on the patio and observed Resident #1 NJ Ex Order 26.4(b)(1) in their wheelchair. The visitor went back inside the facility and informed a staff member. Resident #1's NJ Ex O was NJ Ex Order 26.4(b)(1); vital signs were: NJ Ex Order 26.4(b)(1) . Resident #1 was transferred to the Emergency Room and presented as NJ Ex Order 26.4 and with NJ Ex Order 26.4(b)(1) . The resident was diagnosed with NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) | F0000 | | 12/18/2025 |

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0000 | Continued from page 1<br>NJ Ex Order 26.4(b)(1) ) and was admitted to the hospital from NJ Ex Order 26.4(b)(1).<br><br>The facility's failure to ensure Resident #1 was free from NJ Ex Order 2 by failing to NJ Ex Order 26 Resident #1 when they were in NJ Ex Order 26.4(b)(1) posed serious NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) to Resident #1 which resulted in an Immediate Jeopardy (IJ) situation.<br><br>The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were informed of the IJ and was provided with the IJ template on NJ Ex Order 26.4(b) at 5:16 PM. The IJ was determined to be Past Non-Compliance (PNC).<br><br>The facility submitted an acceptable Removal Plan (RP) indicating what actions the facility implemented post incident to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice to include; NJ Ex Order 26.4(b)(1) were implemented on NJ Ex Order 26.4(b)(1) recorded on log sheets. Notifications to NJDOH, Ombudsman Office and facility administrative staff were sent. Patio keypad was changed from opening from 8:00 AM to 8:00 PM to locked. All employees at the facility were educated on Resident Safety NJ Ex Or Advisory. CNA #1 received inservice/education on Resident Safety and CNA #2 received inservice/education on Resident Safety, knowing your assigned resident's whereabouts, making rounds on assigned residents and received a 3-day suspension. A facility wide inservice on the new Outdoor Resident Policy was initiated with Resident Safety/Updated Log Sheets and NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 was completed. In addition, NJ Ex Order 26.4(b)(1) remain on al NJ Ex Order 26.4(b)(1) recorded on log sheets.<br><br>The facility self-corrected the deficient practice, and it was determined that the IJ was PNC. The facility corrected their non-compliance on 7/11/25.<br><br>The survey team verified the implementation of the Removal Plan on-site on 10/31/25 during the continuation of the survey. | F0000 | | |
| F0600<br>SS = SQC-J | Free from Abuse and Neglect<br><br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation<br><br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and | F0600 | "Past Noncompliance - no plan of correction required" | 11/27/2025 |

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| F0600 SS = SQC-J | Continued from page 2<br>exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Complaint # 2561976<br><br>Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure residents were protected from NJ Ex Order 2 after an NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) resident (Resident #1), was NJ Ex approximately 12:50 PM until approximately 3:30 PM on NJ Ex Order 26.4(b)(1) ). Resident #1 was sent to the hospital, was diagnosed with NJ Ex Order 26.4(b)( and NJ Ex Order 26.4(b)(1) . This deficient practice was identified for 1 of 2 residents, (Resident #1) reviewed for NJ Ex Order 26<br><br>On 7/3/25 at approximately 12:50 PM, a Certified Nursing Assistant (CNA #1) transported Resident #1 (who was NJ Ex Order 26.4(b)(1) and required NJ Ex Order 26.4(b)(1) ), in a wheelchair to the NJ Ex Order 26.4(b)(1) . CNA #1 did not communicate to other facility staff that Resident #1 was NJ Ex Order 26.4(b)(1). Resident #1's assigned CNA (CNA #2) nor did any other staff did not check on the resident from 12:20 PM through the end of her shift which was 3:00 PM.<br><br>At approximately 3:20 PM, Resident #2 and a visitor were on the patio and observed Resident #1 NJ Ex Order 26.4(b)(1) in their wheelchair. The visitor went back inside the facility and informed a staff member. Resident #1's NJ Ex O was NJ Ex Order 26.4(b)(1); vital signs were: NJ Ex Order 26.4(b)(1) . Resident #1 was transferred to the Emergency Room and presented as NJ Ex Order 26.4 and with NJ Ex Order 26.4(b)(1) . The resident was diagnosed with NJNJ Ex Order 26.4(b)( and NJ Ex Order 26.4(b)(1) (NJ | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 3<br>NJ Ex Order 26.4(b)(1)) and was admitted to the hospital from NJ Ex Order 26.4(b)(1).<br><br>The facility's failure to ensure Resident #1 was [redacted] from [redacted] by failing to [redacted] Resident #1 when they were in NJ Ex Order 26.4(b)(1) [redacted] posed NJ Ex Order 26.4(b)(1) and [redacted] to Resident #1 which resulted in an Immediate Jeopardy (IJ) situation. The IJ was determined to be Past Non-Compliance.<br><br>The IJ began on [redacted] at approximately 12:50 PM, after Resident #1 was NJ Ex Order 26.4(b)(1) [redacted].<br>The facility corrected the immediacy on 7/11/2025, by implementing the following: NJ Ex Order 26.4(b)(1) changed from operation from 8 AM to 8 PM to locked; NJ Ex Order 26.4(b)(1) [redacted]; facility wide re-education on "Outdoor Resident Policy" and "Resident Safety/Updated Log Sheets;" re-education to CNA #1 and CNA #2; and NJ Ex Order 26.4(b)(1) checks.<br><br>The facility's U.S. FOIA (b) (6) [redacted] was notified of the IJ on 10/31/25 at 5:16 PM.<br>The facility submitted an acceptable Removal Plan (RP) and the survey team verified the implementation of the RP on-site on 10/31/25 during the continuation of the survey.<br><br>The evidence was as follows:<br><br>A review of the facility's "Abuse Prohibition Policy," dated 3/26/2024, provided by the U.S. FOIA (b) (6) [redacted]), included a policy statement that the facility would "provide a safe resident environment where residents are free from abuse, neglect, misappropriation of property and exploitation." "Abuse" was defined by the Code of Federal Regulations (CFR) 483.5 as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being." "Neglect," was defined by CFR 483.5 as "the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress." "Willful" was defined by CFR 483.5, and used in the definition of "abuse", means "the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 4<br><br>On 10/31/25 at 9:50 AM, the surveyor observed Resident #1 in bed with their eyes closed. The surveyor was NJ Exec Order 26.4b1 Resident #1.<br><br>A review of the facility initiated Reportable Event Record/Report dated NJ Ex Order 26 and completed by the U.S. F revealed: "Resident was noted NJ Ex Order 26.4(b)(1) in [their] wheelchair, resident was NJ Ex Order 26.4(b)(1), and US FOIA (b)(6) ) was notified of condition; NJ Exec Order called. Resident was admitted to the hospital for NJ Ex Order 26.4(b)(1) at 6:55 P. [PM]."<br><br>A review of the investigation provided by the U.S. F revealed statements from CNA #1 explaining that she was in the dining room and brought Resident #1 in a wheelchair NJ Ex Order 26.4(b)(1 after lunch at approximately 12:50 PM. CNA #1 had not communicated to anyone that Resident #1 was NJ Ex Order 26 A statement from Resident #2 explained that they were NJ Exec Order 26.4b1 with a guest and saw Resident #1's NJ Ex Order 26.4(b)(1) and the resident NJ Ex Order 26.4(b)(1), and the guest informed the staff. In addition, the investigation revealed CNA #2 was assigned to Resident #1 but there was no written statement from CNA #2. The U.S. F documented CNA #2 was not aware of the resident's NJ Ex Order 26.4(b)(1) when the resident finished lunch until the end of CNA #2's shift at 3:00 PM. CNA #2 reported that after lunch until the end of her shift she was providing care/rounding on the other residents assigned to her during the shift. CNA #2 also reported she was unable to recall the NJ Ex Order 26.4(b)(1) Resident #1.<br><br>A review of an "Employee Discipline Notice" dated NJ Ex Order, revealed CNA #2 had NJ Exec Order 26.4b1 and "Employee's assigned resident was not NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) for extended period of time."<br><br>A review of a "Job Description" for "Certified Nursing Assistant" with CNA #2's name on it included but was not limited to; responsibilities to "Conduct resident rounds as assigned," and "Be responsible for the safety of residents under his/her supervision."<br><br>On 10/31/25, surveyor reviewed the electronic medical record for Resident #1.<br><br>A review of the Resident Face Sheet (an admission summary), reflected that Resident #1 was admitted to the facility with diagnoses that 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) | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 5<br>NJ Ex Order 26.4(b)(1) ), NJ Ex Order 26.4(b)(1) ), and NJ Ex Order 26.4(b)(1)<br><br>A review of the comprehensive quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, revealed that a Brief Interview for Mental Status (BIMS) score was not able to be obtained because the resident was NJ Ex Order 26.4(b)(1). In addition, the MDS indicated the resident had NJ Ex Order and NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1) . A further review of the MDS, revealed the resident required NJ Ex Order 26.4(b)(1) and activities of daily living for NJ Ex Order 26.4(b)(1) .<br><br>A review of the individual comprehensive Care Plan Activity Report (CPAR) included a focus area dated NJ Ex Order 26, for NJ Ex Order 26.4(b)(1) . Interventions included but were not limited to; monitor for any changes in NJ Ex Order 26.4(b)(1) resident to NJ Ex Order 26.4(b)(1) as needed. There was no focus area in relation to NJ Ex Order 26.4(b)(1) .<br><br>A review of a Nursing Progress Note (NPN) dated NJ Ex Order at 9:27 PM by the U.S. FOIA (b) (6) ), revealed "Resident observed in WC (wheelchair) with NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1). Call placed to US FOIA (b)(6) ) with immediate response for orders to send to ER (emergency room). NJ Ex O called. Family advised. Nursing staff present with resident until transferred to [hospital name redacted] further eval (evaluation)." In addition, another PN or NJ Ex Order 2 at 7:52 AM revealed "The resident was admitted to the hospital with diagnosis of NJ Ex Order 26.4(b)(1) and NJ Ex Ord at 6 PM."<br><br>A review of the hospital records, provided by the U.S. FO revealed a "Progress Note" with an admission date NJ Ex Order 2 at 4:30 PM, and chief complaint of "NJ Ex Or " The "History of Present Illness:" included: "[Resident #1] presents to the Emergency Department today altered. Patient was brought in from [inaccurate facility name redacted] via EMS (emergency medical services) who report [they] had NJ Ex Order 26.4(b)(1). Per EMS, patient was NJ Ex Order 26.4(b)(1) after unknown amount of time around lunchtime. Patient is NJ Ex Order 26.4(b)(1) ) at baseline Otherwise: Per EMS, patient denies NJ Ex Orde NJ Ex Order 26.4(b)(1) , and other NJ Ex Orde | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 6<br>NJ Ex Order 26.4(b)( at this time. NJ Ex Order 26.4(b)(1) due to NJ Ex Orde . ER work-up was noted, patient was admitted for further management." The NJ Exec Order 26.4b1 " indicated "General: pt (patient) is in NJ Ex Order 26.4(b)(1) ."<br><br>Also, the hospital records revealed a " NJ Ex Order 26.4(b)(1) Consult" dated NJ Ex Order at 9:54 AM, indicated "History of Present Illness:" included: "[Resident #1] presents to the Emergency Department today NJ Ex Order 26. "Patient was brought in from [inaccurate facility name] via EMS who report [they] had NJ Ex Order 26.4(b)(1) . Per EMS, patient was NJ Ex Order 26.4(b)(1) after unknown amount of time around lunchtime, NJ Ex Order 26.4(b)(1 [their] wheelchair. Patient is NJ Ex Order 26.4(b)(1) at baseline and patient required and received my immediate attention. Otherwise: Per EMS, patient denies NJ Ex Order 26.4(b)(1) , and other NJ Ex Order 26.4(b)(1) at this time. NJ Ex Or due to NJ Ex Order 26.4(b)(1) . Principal Problem: NJ Ex Order 26.4(b)(1) The assessment was " NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) , principal problem: NJ Ex Order 26.4(b)(1)<br><br>Further review of hospital records revealed a " NJ Ex Order 26.4(b) Consult" dated NJ Ex Order at 7:41 AM, indicated that the resident was brought to the hospital due to a NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . "In emergency room patient was NJ Ex Order 26.4(b)(1) NJ Ex Order 26 and NJ Ex Order NJ Ex Order 26.4(b)(1) was NJ Exec Order 26 for NJ Ex Order 26.4(b)(1) . In the emergency room patient was NJ Ex Order 26.4(b and " NJ Ex Order 26.4(b)(1) ". Unclear if [Resident #1] had NJ Ex Order 26.4(b)(1) . No report of any NJ Ex Order 26.4(b)(1) Currently patient is NJ Ex Order 26.4(b)(1) but NJ Ex Order 26.4 The assessment indicated "[Resident #1] with NJ Ex Order 26.4(b)(1) Likely NJ Exec Order 26.4b1 due to NJ Ex Order 26.4(b)( . Cannot rule out NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b)(1) ."<br><br>Additionally, the hospital records revealed a " NJ Ex Order 26.4(b)( Consult" dated NJ Ex Order 2 at 10:43 AM, revealed an assessment which included "[Resident #1] who came in with NJ Ex Order 26.4(b)(1) most likely due to NJ Ex Order 26.4(b)(1) and we are called for NJ Ex Order 26.4(b)(1) ."<br><br>Further review of the resident's medical records provided by the hospital revealed the following:<br><br>A review of the hospital emergency room plan of care NJ Ex Order , revealed "Patient is admitted. Upon ED [ER] evaluation, it has been determined that NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(b) | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 8<br>NJ Ex Order assessment included NJ Ex Order 26.4(b)(1) [redacted]" The assessment indicated NJ Ex Order 26.4(b)(1) ."<br><br>A review of the Nursing-Weekly NJ Ex O Assessment completed NJ Ex Order 26., revealed NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1 record that indicated "NJ Ex Order 26.4(b)(1) [redacted])."<br><br>On 10/31/25 at 9:51 AM, the surveyor interviewed CNA #3 who was assigned to Resident #1. CNA #3 stated she worked for an NJ Exec Order but has worked consistently at the facility since NJ Ex Order 26.4(b)(1) and was familiar with Resident #1. CNA #3 explained the resident just recently was on NJ Exec Order 2 so that morning the NJ Exec Order 2 aide had provided care. CNA #3 added that the resident required NJ Ex Order 26.4(b) but was able to NJ Ex Order 26.4(b)(1). CNA #3 also stated that the resident sometimes could NJ Ex Order 26.4(b)(1) but then NJ Ex Order 26.4(b)(1)" and having NJ Ex Order 26.4(b)(1) with the resident was NJ Ex Order 26.4(b)(1). CNA #3 stated she was able to figure out if the resident NJ Ex Order 26.4(b)(1) through NJ Ex Order 26.4 CNA #3 added the resident loved to NJ E , so if the resident saw through the NJ Exec Order 26.4b1 , they would want to NJ Ex Order 26.4(b)( and there was a NJ Ex Order 26.4(b)(1) that was easy to NJ Ex Orde. CNA #3 also stated that the resident could not NJ Ex Order 26.4(b)(1) and would have to be taken in the wheelchair NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) by staff.<br><br>On 10/31/25 at 10:00 AM, the surveyor interviewed the Licensed Practice Nurse /Unit Manager (LPN/UM #1) who stated there were residents who liked to NJ Ex Order 26.4(b)(1) [redacted] and there was now a log to complete when residents NJ Ex Order 26.4(b)(1). LPN/UM #1 also stated Resident #1 loved to NJ Ex Order 26.4(b)(1) , only when it was NJ Ex Order 26.4(b)(1). LPN/UM #1 added that she was made aware of the NJ Ex Order incident with Resident #1 afterwards because she was not at the facility.<br><br>On 10/31/25 at 10:13 AM, the surveyor interviewed the U.S. FOIA (b) (6) ) who stated that there were some NJ Ex Order 26.4(b)(1) that her department was responsible for but there was more than NJ Ex Order 26.4(b)(1), and residents could go to those areas when they wanted. The U.S. FOIA stated that she was aware of what happened to Resident #1 in NJ Ex O but Resident #1 was not attending at NJ Ex Order 26.4(b)(1) The U.S. FOIA added that during NJ Ex Order 26.4(b)(1) the | F0600 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ROSE GARDEN NURSING AND REHABILITATION CENTER | 1579 OLD FREEHOLD ROAD , TOMS RIVER, New Jersey, 08753 |

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| F0600 SS = SQC-J | Continued from page 9<br>activity staff was responsible for being aware of resident NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) The U.S. FOIA stated she had signage that would be posted on all doors that went outside when there was a NJ Ex O advisory during NJ Exec Order 26.4b1 to make staff, visitors and residents aware. The surveyor with the U.S. FOIA observed a sign which indicated "NJ Ex Order 26.4(b)(1) [redacted]" and another sign "NJ Ex Order 26.4(b)(1) In Effect, Please be sure to NJ Ex Order 26.4(b)(1) if you are NJ Ex Orde [redacted]. All Nursing stations has NJ Ex Order 26.4(b)( for resident use."<br><br>On 10/31/25 at 10:20 AM, the surveyor interviewed the U.S. FOIA (b) (6) ) who stated that she had been U.S. FOIA since NJ Ex Order 26.4(b)(1). The U.S. FOIA also stated she was aware of the occurrence with Resident #1 and the U.S. F had completed the "Reportable Event Record/Review" that was sent to the New Jersey Department of Health (NJDOH) and completed the investigation. The U.S. FOIA added that CNA #1 was still employed but CNA #2 was no longer employed at the facility.<br><br>On 10/31/25 at 11:07 AM, the surveyor interviewed the U.S. F who stated that the normal process when a resident was taken outside was to make the primary nurse and assigned U.S. FOIA aware that the resident was outside, and it was the responsibility of the U.S. FOIA assigned to the resident to check on them. The U.S. F stated that prior to NJ Exec Order 26.4b1 during the spring and summer was open from 8:00 AM until 8:00 PM, An alarm would sound only if a resident with a NJ Exec Order [redacted]. The U.S. F stated CNA #2 was unwilling to give a written statement or sign a transcription of her verbal statement. The U.S. F added that CNA #2 was unaware Resident #1 was NJ Exec Order2 and that the resident had no medications due during that time. The U.S. F also stated that CNA #2 was assigned to Resident #1 and should have made rounds by 2 PM on all her assigned residents to make sure the basics were completed such as NJ Exec Order 26. residents that needed to be NJ Exec Order 26. providing NJ Exec O and accounting for their residents. The AA added that CNA #2 left her assignment at 3:00 PM and acknowledged that CNA #2 neglected to NJ Ex Order 26 the resident. The U.S. F also stated that a visitor with Resident #2 had NJ Exec Order 26 to the NJ Ex Order 26.4(b)(1) NJ Ex Order at approximately 3:20 PM, and that was how the staff was notified that Resident #1 was NJ Ex Order 26.4(b)(1 their wheelchair NJ Ex Order 26.4(b)(1).<br><br>On 10/31/25 at 1:07 PM, the surveyor interviewed CNA #1 via telephone. CNA #1 primarily NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1) with her on the phone. CNA #1 stated she had worked at the facility for approximately | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 10<br>NJ Ex Order 26.4(b)(1) and explained prior to NJ Ex O that when a resident was brought to the NJ Ex Order 26.4(b)(1) and you were not the assigned CNA, you should communicate to the nurse or the assigned CNA to let them know the resident NJ Ex Order 26.4(b)(1). CNA #1 added that if any of her assigned residents were NJ Ex Order 26. she was responsible for checking on them every NJ Ex Order 26.4(b)(1 to see if they wanted to NJ Ex Order 26.4(b)(1), needed NJ Ex Orde or needed to NJ Ex Order 26 . CNA #1 also stated that it was the responsibility of the CNA to NJ Ex Order 26.4(b)(1), check if they wanted NJ Ex Order 26.4(b)(1). CNA #1 stated that she remembered the incident with Resident #1 in NJ Ex O because she had brought the resident NJ Ex Order 26.4(b)(1) after they finished lunch in the dining room at approximately 12:50 PM and then she went to lunch. CNA #1 added that NJ Ex Order 26.4 was not far from the dining room, approximately 3 to 5 feet. CNA #1 stated she forgot to communicate to the nurse or assigned CNA. CNA #1 stated "I made a big mistake." CNA #1 also stated that the resident had NJ Ex Order 26.4(b)(1) with them and thought they could NJ Ex Order 26.4(b)(1). CNA #1 also stated she had not NJ Ex Order 26.4(b)(1) because she placed the resident in NJ Ex Order 26.4(b) because it was NJ Ex Orde CNA #1 added that the resident could NJ Ex Order 26.4(b)(1) but did not NJ Ex Order 26.4(b)(1).<br><br>On 10/31/25 at 2:05 PM, the surveyor interviewed the U.S. F who stated that NJ Ex Order 26.4(b)(1) were provided on the NJ Ex Orde and signs regarding NJ Ex Order 26.4(b)(1) Precautions were on the doors to the outside all NJ Exec Order 2 until after approximately the NJ Exec Order 26.4b1 . The U.S. F added that it was the responsibility of the staff, usually the CNA, to NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 if a resident was unable to do it by themselves. The U.S. F also stated that prior to NJ Ex Order 2 there was no policy regarding residents NJ Ex Order 26.4(b)(1).<br><br>On 10/31/25 at 3:50 PM, the surveyor interviewed the U.S. F who stated Resident #1 was a NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4 and could NJ Exec Order 26.4b1 in a wheelchair NJ Ex Orde but NJ Ex Order 26.4(b)(1) would be "challenging." The U.S. F also stated that she thought Resident #1 would be able to NJ Ex Order 26.4(b)(1). The U.S. F acknowledged that Resident #1 should have been monitored. The U.S. F was unable to answer to the NJ Ex Order 26 Resident #1 was NJ Ex Order 26. or NJ Ex Order 2 or a NJ Ex O assessment prior to being transferred because NJ Exe was called immediately and the resident was sent out to the hospital.<br><br>The facility submitted an acceptable Removal Plan (RP) indicating what actions the facility implemented post incident to prevent serious harm from occurring or recurring. The facility implemented a corrective action | F0600 | | |

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| F0600 SS = SQC-J | Continued from page 11<br>plan to remediate the deficient practice to include; NJ Ex Order 26.4(b)(1) were implemented on a NJ Ex Order 26.4(b)(1) ) for NJ Exec Order 26.4b1 recorded on log sheets. Notifications to NJDOH, Ombudsman Office and facility administrative staff were sent. NJ Ex Order 26.4(b)(1) was changed from opening from 8:00 AM to 8:00 PM to locked. All employees at the facility were educated on Resident Safety NJ Ex Or Advisory. CNA #1 received inservice/education on Resident Safety and CNA #2 received inservice/education on Resident Safety, knowing your assigned resident's whereabouts, making rounds on assigned residents and received a 3-day suspension. A facility wide inservice on the new Outdoor Resident Policy was initiated with Resident Safety/Updated Log Sheets and NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 was completed. In addition, NJ Ex Order 26.4(b)(1) remain on all outdoor areas recorded on log sheets.<br><br>The facility self-corrected their non-compliance on 7/11/25.<br><br>The surveyor verified the implementation of the RP on-site on 10/31/25 during a continuation of the survey.<br><br>NJAC 8:39-4.1(a)(5) | F0600 | | |