STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. BUILDING _____ B. WING _____	C 05/08/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not 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		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		5/25/24

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

Electronically Signed | 05/24/2024

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.

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of the facilities Emergency Preparedness Plan and Program (EPP), it was determined that the facility failed to ensure that the EPP was reviewed and updated at least annually. This deficient practice was evidenced by the following: On 04/26/2024 at 11:20 AM, the surveyor conducted a review of the facilities EPP. The review did not reveal any evidence that the EPP had been reviewed and updated for 2023. On 04/26/2024 at 01:17 PM, the surveyor conducted an interview with the facility U.S. FOIA (b)(6) U.S. FOIA (b)(6)) who identified himself as the responsible person for the facility EPP, when and where was documentation for the EPP being reviewed and updated for 2023. The U.S. FOIA (b) replied, "I inherited the Emergency Preparedness Manual task in November 2023 from our previous director. The surveyor asked the U.S. FOIA (b)(6) when the facility EPP is updated annually? The U.S. FOIA (b)	E 004	2024 Survey - Plan of Correction Effective: 5.8.24 E004- Emergency Preparedness 1. To correct the deficient practice the IDT consisting of the following team members met on 5.14.24 to review the EPP manual making updates and revisions: Administrator, Assistant Administrator, DON, ADON, Director of Social Services, Director of Maintenance, Director of Admissions, Director of Dietary, and Comptroller. The attendance sheet was signed by all attendees and is maintained in the EPP manual. 2. All residents had the potential to be affected by the deficient practice. 3. The DOM will be responsible for monitoring the deficient practice. 4. To ensure that the deficient practice is being corrected and will not recur, the DOM will be responsible for scheduling	

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E 004	Continued From page 2 stated, "We just kind of update it whenever and add and subtract as we go along. I kind of do it myself and we don't meet to go over it. This should have more input from others in the facility." On 04/30/2024 at 10:05 AM, the surveyor interviewed the facility U.S. FOIA (b)(6) U.S. FOIA (b) and asked the U.S. FOIA if she was aware that the EPP had to be reviewed and updated at least annually. The U.S. FOIA replied, "Yes, I understand that the EPP needs to be reviewed and signed annually." A review of the facility provided policy titled Emergency Preparedness Drills, undated, did not address the annual updating of the facility EPP. NJAC 8:39-31.2(e)	E 004	meetings at a minimum of annually for the IDT to review, update and revise the EPP manual. All attendees will sign the attendance sheet and it will be maintained in the EPP manual. The DOM will submit a QAPI to the QAPI committee for review and recommendations. The QAPI committee meets quarterly and will determine the need for continued monitoring.	
F 000	INITIAL COMMENTS Standard Survey 4/30/2024 Census: 109 Sample Size: 24 + 1 closed record C/O # NJ 166502 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F 582		5/25/24

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F 582	Continued From page 3 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or	F 582		

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F 582	Continued From page 4 resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for NJ Exec Order 26.4b1 [redacted], (Resident #32 and Resident #73). This deficient practice was evidenced by the following: The surveyor reviewed the NJ Exec Order 26.4b1 [redacted] completed by the facility for Resident #32. The NJ Exec Order 26.4b1 indicated the residents last covered Medicare day was 02/29/2024 and the resident remained in the facility. The NJ Exec Order 26.4b1 further revealed that a 'NJ Exec Order 26.4b1 [redacted]" was given to Resident #32. When the surveyor requested a copy, the US FOIA (b)(6) [redacted] provided the surveyor with a copy of Resident #32's signed Admission Agreement. The surveyor reviewed the NJ Exec Order 26.4b1 [redacted] ompleted by the facility for Resident #73. The NJ Exec Order 26.4b1 indicated the residents last covered NJ Exec Order 26.4b1 day was NJ Exec Order 26.4b1 and Resident #73 remained in the facility. The NJ Exec Order 26.4b1 further revealed that a NJ Exec Order 26.4b1 [redacted]	F 582	2024 Survey - Plan of Correction Effective: 5.20.24 F582- Medicaid/Medicare coverage/Liability Notice 1. No residents were affected by the deficient practice. 2. The facility administration provided a skilled nursing facility NJ Ex Order 26.4b1 [redacted] to residents (R73) and (R32). All residents have the potential to be affected by deficient practice. 3. To ensure that the deficient practice is corrected a root cause analysis was completed which identified gaps in staff education and laps in formal policy and procedure. The Social Services department will review all residents who have a last covered day for skilled Medicare services to assure ABN (CMS form 10055) was received. a. Education was provided to all social services team members on ABN's, (CMS form 10055) and social services will be responsible for the corrective action. b. Increased Oversight- The Director of Social Services will assume the responsibility for assuring the facility is complaint.	

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F 582	Continued From page 5 NJ Exec Order 26.4b1 " was given to Resident #73. When the surveyor requested a copy, the [redacted] provided the surveyor with copy of Resident #73's signed Admission Agreement. During an interview with the surveyor on 04/24/2024 at 12:32 PM, the [redacted] said this comes up every year at survey as we use section 5 of the admission agreement as the [redacted] When the surveyor asked the [redacted] do you use the CMS -10055 form, the [redacted] said no. Historically we only use the admission agreement. The surveyor reviewed the form with the [redacted], and she said yes, I know about that form. We are waiting to see if we are told to change our practice. During a follow-up interview with the [redacted] on 04/24/2024 at 12:41 PM, the [redacted] clarified that we are waiting to see if it ever came up with survey and that we are not able to utilize this (admission agreement). Every survey we are questioned but it never comes up as an issue.	F 582	4. The Director of Social Services will complete a weekly audit for the first 30 days for the residents ABN's. If after one month, 100% compliance is achieved, the audit will move to monthly review for 2 or more months. The result of the audits will be presented at the monthly performance improvement meeting for review and recommendations. The QAPI team meets quarterly, and the Director of Social Services will provide a copy of the report to the Administrator. The QAPI committee will determine the need for continued monitoring.	
F 658 SS=D	NJAC 8:39-4.1(a)(7) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record and other facility documentation, it was determined that the facility	F 658	Plan of Correction: 2024 Survey F658 – Services Provided Meet Professional Standards	7/1/24

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F 658	Continued From page 6 failed to follow a physician order for weekly weights on 1 of 3 residents reviewed for nutrition. 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 professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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." According to the Face Sheet, Resident #54 was admitted to the facility with diagnoses including but not limited to: NJ Ex Order 26.4b1 [redacted]	F 658	1. 1 resident (#54) mentioned in F658 had NJ Exec Order 26.4b1. 2. All residents have potential to be affected by the deficient practice. 3. To ensure that the deficient practice is corrected a root cause analysis was completed which identifies gaps in staff education and oversight. The systemic changes that have been made include the following: a. Staff Education – the nurses were educated via in-service about the importance of documenting weights. To ensure that nurses are aware of the weekly weights that are ordered every Monday, the night/evening shift will run a report of the weights on Monday morning. The night/evening shift nurse will print a list of weekly weights to share in shift-to-shift report with day shift nurse. Taking “resident centered care” into account, all weekly weights orders were revised to be obtained on 7-3 shift. b. Increased Oversight – the unit manager (UM)/ designee will reinforce the list of weights that need to be obtained in morning huddle and then closer to end of dayshift, UM will huddle with staff to ensure completion of the task. Refusals will be documented. 4. To ensure that the deficient practice is being corrected and will not recur, is by direct oversight of the dietician who will conduct weekly audit X 1 month then bi-monthly audits for 1 month. A written report will be completed by the dietician and reviewed by the Director of Nursing and/or Clinical Care Administrator. In	

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F 658	Continued From page 7 On 04/24/24 at 11:47 AM, Resident #54 was observed seated in the dining room eating lunch. Resident #54's lunch consisted of a Ex Order 26.4B1 diet that included roasted turkey, grilled zucchini, stuffing, gravy, cheesecake, juice, protein shake, and high protein jello. A review of the Resident Physician Orders with a start date of Ex Order 26.4B1 revealed a physician order for Ex Order 26.4B1 on Monday before breakfast or any intake. A review of the Medication Administration Records (MAR) for the months of Ex Order 26.4B1 and Ex Order 26.4B1 showed the physician order for Ex Order 26.4B1 The blocks for Ex Order 26.4B1 and Ex Order 26.4B1 were blank. There was no documentation to indicate that the Ex Order 26.4B1 had been completed as ordered. A review of the Electronic Medical Record (EMR), in the [redacted] section, there was no documentation of the Ex Order 26.4B1 for the aforementioned. During an interview with the surveyor on 4/29/24 at 9:48 AM , Licensed Practical Nurse (LPN #2) said that NJ Exec Order 26.4 are usually done by the U.S. FOIA (b)(6) [redacted] at 6 AM prior to breakfast. We (the nurses) would let the aides know who is popping up for Ex Order 26.4B1. If they were to refuse weekly Ex Order 26.4B1 the Unit Manager would be notified and then it is replotted for the next morning. During an interview with the surveyor on 4/29/24 10:10 AM, U.S. FOIA (b)(6) [redacted] revealed that weekly NJ Exec Order 26.4 are done on Mondays between 7 AM and 3 PM. It	F 658	addition, the dietician has started a QAPI plan specific for the Weekly weights. The findings will be reported to the Administrator and to the QAPI committee quarterly who will determine the need for continued monitoring. Completion date: July 1, 2024	

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F 658	Continued From page 8	F 658		

is done for 4 (four) weeks after the resident is admitted, then monthly. The [redacted] will review the [redacted]. If there is no stop date (on the physician order), the [redacted] should continue. [redacted] also stated that nursing usually [redacted] the resident and the [redacted] should be documented in the resident's Medication Administration Record (MAR). During the interview the [redacted] accessed Resident # 54's electronic medical record and stated, "Yeah, he/she's weekly ([redacted] since [redacted] The [redacted] confirmed that the MAR was blank for [redacted]. The [redacted] replied "yes" when asked, is it fair to say that if there is no documentation, the [redacted]) was not done.

During an interview with the surveyor on 4/29/24 at 1:08 PM, the [redacted]) revealed that the CNAs are usually tasked to [redacted] the residents and it is the nurses responsibility to make sure the task is delegated to the CNA. The [redacted] continued to say that due to staffing challenges, the nurses [redacted] the residents and the [redacted] should be documented in the MAR. The [redacted] further stated, there should be documentation if the resident refuses to be [redacted]

A review of a the facility policy titled Weight Monitoring, undated, under the procedure for monitoring weights section revealed "Weekly weights will be done when ordered by the physician, recommended by the Dietician, or as a nursing intervention."

A review of a facility policy titled Physician's Orders, undated, under the note section revealed "Each Physician order shall be executed by the nursing, Dietary, Social Work, Activities, Rehab,

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F 658	Continued From page 9 or Pharmacy service as appropriate in accordance with professional standards of practice. If the order cannot be carried out within 24 hours, the reason for this must be documented in the medical record and the Physician notified." NJAC 8:39-27.1(a)	F 658		
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 the medical record and other facility records, it was determined that the facility failed to consistently assess or measure [NJ Exec Order 2] [redacted] for a resident with an order for PRN (as necessary) [redacted] use. This deficient practice occurred for 1 of 4 residents (Resident #46) reviewed for [NJ Exec Order 26.4b1] care. This deficient practice was evidenced by the following: On 04/23/2024 at 11:05 AM, the surveyor observed an Ex Order 26.4B1 against the wall in Resident #46's room. The Ex Order 26.4B1 was not observed to be in use and according to nursing staff Resident #46 didn't use it [Ex Order 26.4B1])	F 695	Plan of Correction: 2024 Survey Effective date: May 9, 2024 F695 – Respiratory Tracheostomy care and suctioning 1. 1 resident (#46) mentioned in F695, [redacted] An immediate audit of all PRN [NJ Ex] orders was conducted and policy reviewed. Audit showed only #46 resident's order read '[redacted]. Order revised	7/1/24

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F 695	Continued From page 10 regularly. According to the Resident Face Sheet Resident #46 was admitted with diagnoses including but not limited to: Ex Order 26.4B1 [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool, dated Ex Order 26.4B1 revealed a Brief Interview for Mental Status score of [redacted], indicating Ex Order 26.4B1 [redacted]. According to Section [redacted] Resident #46 did not have Ex Order 26.4B1 [redacted] Section [redacted] did not indicate that Resident #46 received Ex Order 26.4B1. A record review for Resident #46 was initiated on NJ Exec Order 26.4b1 at 1:53 pm and continued NJ Exec Order 26.4b1 upon arrival to the facility. The medical record included the following physician order: "Ex Order 26.4B1 [redacted] (as necessary) for NJ Exec Order 26.4b1 [redacted] Ex Order 26.4B1 or Ex Order 26.4B1 [redacted]. Start Date: Ex Order 26.4B1." On 04/25/2024 at 09:55 AM the surveyor reviewed the electronic medical record (EMR) for Resident #46. The Ex Order 26.4B1 Medication Administration Record (MAR) revealed that Resident #46 had the following order:	F 695	per policy to read, "Administer [redacted] at [redacted] or NJ Exec Order 26.4b1 [redacted]". Immediate Inservice for all nurses was conducted for order entry. 2. All residents who use oxygen have potential to be affected. 3. To ensure that the deficient practice is corrected, a root cause analysis was completed which identifies gaps in staff education and updating of policy. The systemic changes that have been made include the following: a. Staff Education – the nurse was educated via in-service about order entry (complete and concise order), clarifying order with MD and checking for duplicate orders. The order should read, 'NJ Ex Order 26.4b1 [redacted]". b. Policy Update – All prn o2 orders will be reviewed. The consultant will review all orders, including Prn O2 orders in his monthly review. After review, the consultant will recommend discontinuing the PRN orders if not used in 30 days. 4. To ensure that the deficient practice is being corrected and will not recur, is by direct oversight of the Unit manager/desk nurse who will conduct weekly audits for prn o2 orders for 1 month then bi-monthly for 1 month. A written report will be completed and reviewed with the Director of Nursing and/or Clinical Care Administrator. The findings will be reported to the Administrator and to the QAPI committee quarterly who will determine the need for continued	

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	315421	A. BUILDING _____ B. WING _____	C 05/08/2024

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F 695	Continued From page 11 "Administer Ex Order 26.4B1 Ex Order 26.4B1 PRN (as needed) if Ex Order 26.4B1 drops below NJ Exec Or Start Date: NJ Exec Order 26.4b1 03:21 PM." There is no evidence on the NJ Exec Order 26.4b1 to indicate that the facility was monitoring NJ Exec Order for Resident #46. The surveyor then requested a copy of NJ Exec Order monitoring for Ex Order 26.4B1. In addition, the surveyor requested from the facility U.S. FOIA (b)(6)) copies of the MAR and Treatment Administration Record (TAR) for the following: Ex Order 26.4B1 On 04/25/2024 at 11:05 AM the surveyor spoke with facility U.S. FOIA (b)(6) The surveyor asked if Resident #46 only had Ex Order 26.4B1 for the dates of Ex Order 26 and Ex Order 26.4B1 and no NJ Exec Order 26.4 for the previous 23 days of NJ Exec Order 26.4b1 The U.S. FOIA (b)(6 then proceeded to go into Resident #46's EMR to bring up Resident #46's Ex Order 26.4B1 s for Ex Order 26.4B1. The U.S. FOIA (b) was unable to find any Ex Order 26.4B1 for the month of Ex Order 26.4B Ex Order 26 in the electronic health record. The surveyor utilized the EMR to get Ex Order 26.4B monitoring from Ex Order 26.4B1 up to Ex Order 26.4B1. The following results were obtained: Ex Order 26.4B1 Ex Order 26.4B1 08:00 am Administration Record Ex Order 26.4B1 Ex Order 26.4B1 10:05 pm Administration Record Ex Order 26.4B1 Ex Order 26.4B1 08:42 am Administration Record Ex Order 26.4B1 Ex Order 26.4B1 12:18 am Administration Record Ex Order 26.4B1 Ex Order 26.4B1 01:01 pm Administration Record Ex Order 26.4B1 Ex Order 26.4B1 12:02 am Administration Record Ex Order 26.4B1 Ex Order 26.4B1 09:26 am Administration Record	F 695	monitoring. In-service: On order entry (complete and concise order), clarifying order with MD and checking for duplicate orders.	

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Continued From page 12

Ex Order 26.4B1 Ex Order 26.4B1
11:48 pm Administration Record
Ex Order 26.4B1 Ex Order 26.4B1
08:04 am Administration Record
Ex Order 26.4B1 Ex Order 26.4B1
08:42 pm Administration Record
Ex Order 26.4B1 Ex Order 26.4B1
01:15 am Administration Record
Ex Order 26.4B1 Ex Order 26.4B1
08:00 am Administration Record

There was no documented Ex Order 26.4 from Ex Order 26.4B1 when a new order for Ex Order 26.4B1 was written on Ex Order 26.4B1.

At the time of entrance to the facility on 04/23/2024, Resident #46 had an active order from Ex Order 26.4B1 for the following:

Ex Order 26.4B1 via Ex Order 26.4 Ex Order 26.4B1 PRN if NJ Exec Order 26 drops below Ex Order 26 Start Date: NJ Exec Order 26.4b1 03:21 PM."

On 04/26/2024 at 09:56 AM, the surveyor conducted an interview with the U.S. FOIA Floor Unit U.S. FOIA (b)(6) The surveyor asked the U.S. FOIA (b)(6) what is the facility policy for the use of PRN ? The US FOIA (b)(6) replied, "I think everybody has an order for PRN NJ Exec Order 26.4b1 or NJ Exec Order 2 We do vitals every shift for subacute residents, and we do vitals for long term resident's weekly unless otherwise stated." The surveyor asked U.S. FOIA (b)(6) if Resident #46 was considered NJ Ex Order 26.4b1. U.S. FOIA (b)(6) stated, yes, he/she is. We put him/her NJ Ex Order 26.4b1 recently because he/she had issues with their NJ Exec Order 26.4b1 but they are fine now." The U.S. FOIA (b)(6) further mentioned we do vital signs weekly and of course

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F 695	Continued From page 13 we can see when he/she is Ex Order 26.4B1." According to the facility policy titled Pulse Oximetry, undated, the procedure section revealed that "All residents on oxygen use must have a Pulse Oximeter check. Residents on continuous oxygen will have their Pulse Oximeter check every shift, and for PRN, will have a Pulse Oximeter check at 9:00 p.m. daily." In addition, the facility Oxygen Administration policy revealed that "All orders for oxygen therapy, either continuous or PRN, shall also have an order for pulse oximetry tests (SPO2) at least once daily, but more often if appropriate for the resident's condition and need for use of oxygen therapy. See Policy: Pulse Oximetry." On 04/30/2024 at 09:58 AM,the surveyor interviewed the facility U.S. FOIA (b)(6). The U.S. FOIA (b) explained to the surveyor that "During COVID we were checking everyone's symptoms. We actually changed our policy to reflect the new guidance after COVID. We revised the policy (Pulse Oximetry) on May 11, 2023. Up until that point the policy did include checking the NJ Exec Order daily at 9 PM. That was my predecessor's policy." On 04/30/2024 at 10:57 AM, the surveyor conducted an interview with the facility U.S. FOIA (b). The surveyor explained to the U.S. FOIA (b) that Resident #46 had an order dated for the following: 'Ex Order 26.4B1 per minute Ex Order 26.4B1 drops below Ex Order 26 Start Date: Ex Order 26.4B1." The surveyor explained that there is no order to check for Ex Order 26.4B1. The order specifically stated to apply Ex Order 26.4B1 drops below Ex Order 26." The U.S. FOIA (b) agreed that the physician order from	F 695		

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F 695	Continued From page 14 Ex Order 26.4B1 up until changed on Ex Order 26.4B1 would require checking the residents Ex Order 26.4B1 to assess if it was Ex Order 26 or less and provide Ex Order 26.4B1 if necessary. The U.S. FOIA (b) stated, "Yes, I understand now that it has a number parameter and would need to be measured as the order is written."	F 695		
F 725 SS=F	NJAC 8:39-27.1(a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 725		7/1/24

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F 725	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview, review of the Nurse Staffing Report and the PB&J (Payroll Based Journal) report and other facility documentation, it was determined that the facility failed to ensure there was sufficient nursing staff on a 24-hour basis to provide nursing care to the residents. This deficient practice was evidenced by the following: During the initial tour on 04/23/2024 at 10:30 AM, Resident #32 was just getting morning care. Resident #32 said, "They are short of nurses and aides all the time, especially on weekends." On 04/23/2024 at 10:30 AM, Resident #72 stated that they do not have enough aides on the weekends. Resident #72 also stated that he/she did not receive their [redacted] yesterday due to being short staffed. During the Resident Council Meeting on [redacted] NJ Exec Order 26.4b1 at 10:00 AM, 3 of 5 Residents reported there is not enough staff, especially at night. Resident #77 said, [redacted] 1. For the 2 weeks of Complaint staffing from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -07/30/23 had 8 CNAs for 114 residents on the day shift, required at least 14 CNAs. -07/30/23 had 7.5 total staff for 114 residents on the overnight shift, required at least 8 total staff. -07/31/23 had 11 CNAs for 113 residents on the	F 725	Plan of Correction: 2024 Survey F725 – Sufficient Nursing Staff 1. No residents were affected by the deficient practice. 2. All residents have potential to be affected by the deficient practice. 3. To ensure that the deficient practice is corrected, a root cause analysis was completed which identifies Resident to C N A staff ratio isn't met. The systemic changes that have been made include the following: a. Increase Pay rate to retain current Staff and attract new staff. b. New Resident Helping Hand (RHH) position to assist C NA with bed making, transport, tidy up rooms, answer call lights. c. Dining Assistant Training to train staff to assist with feeding residents. d. Sponsor Students for C N A training. e. Therapists assist with ADLS for subacute residents. f. Nurses take C N A assignments. g. Contract with 2 new Staffing Agencies to provide contracted CNAs. 4. To ensure that the deficient practice is being corrected and will not recur, there will be direct oversight of the Director of Nursing and/or Clinical Care Administrator to meet required standards by reviewing Staffing schedule daily for 1 month. Thereafter the Director of Nursing and/or Clinical Care Administrator will check	

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F 725	Continued From page 16 day shift, required at least 14 CNAs. -08/01/23 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/02/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/03/23 had 9 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/04/23 had 9.5 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/05/23 had 8.5 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/06/23 had 10.5 CNAs for 115 residents on the day shift, required at least 14 CNAs -08/07/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/08/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/09/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/09/23 had 10.5 total staff for 115 residents on the evening shift, required at least 11 total staff. -08/10/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -08/11/23 had 9.5 CNAs for 118 residents on the day shift, required at least 15 CNAs. -08/12/23 had 9.5 CNAs for 116 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of staffing prior to survey from 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -04/07/24 had 10 CNAs for 110 residents on the	F 725	every week for 1 month to ensure compliance. The findings will be reported to the Administrator and to the QAPI committee quarterly who will determine the need for continued monitoring. Completion date: July 1, 2024	

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F 725	Continued From page 17 day shift, required at least 14 CNAs. -04/08/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/09/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/11/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/12/24 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -04/13/24 had 7.5 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/14/24 had 8.75 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/14/24 had 10.5 total staff for 107 residents on the evening shift, required at least 11 total staff. -04/14/24 had 4.5 CNAs to 10.5 total staff on the evening shift, required at least 5 CNAs. -04/15/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/16/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/17/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/18/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/19/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/19/24 had 9 total staff for 107 residents on the evening shift, required at least 11 total staff. -04/19/24 had 6 total staff for 107 residents on the overnight shift, required at least 8 total staff. -04/20/24 had 7.75 CNAs to 16.25 total staff on the evening shift, required at least 8 CNAs. During an interview with the surveyor on 04/26/2024 at 09:45 AM, Registered Nurse (RN#1) said, "We are challenged a lot for staff, and we have call outs. We try to have at least 1	F 725		

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F 725	Continued From page 18 desk nurse on the weekend as back up for call out. Also, if you call out on weekend you have to make it up." During an interview with the surveyor on 04/26/2024 at 11:02 AM, Certified Nursing Assistant (CNA #1) said, "We are always short. We have 3 aides today and I have like 19 residents." When asked how is staffing on weekends, CNA #1 said I work every other weekend and we are always short on weekends. When asked how many aides you should have, CNA #1 replied, we are supposed to have eight (8) aides but may have same as today. There are no hospice aides to help on weekends. During an interview with the surveyor on 04/29/2024 at 10:15 AM, the US FOIA (b)(6) said she was aware of the minimum staffing requirements for CNA's which is 1 to 8 residents for 7-3 shift, 1 to 10 for 3-11 shift and 1 to14 for 11-7 shift. When asked if the facility meets those requirements, the US FOIA (b)(6) said, "No." A review of the Facility Assessment last updated 2/15/23 revealed the following: Under 2. Facility Staffing Plan section: Nursing Day Shift 7a-3p 1st floor 1 Unit manager & desk Nurse 3 Nurse 7 CNA's Avg. census:56 Nursing Evening Shift 3p-11p Supervisor 2 Nurses 7 CNA's	F 725		

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F 725	Continued From page 19 Avg. Census: 56 Nursing Night Shift 11p-7a Supervisor 2 Nurses 4CNA's Avg. census: 56 2nd Floor Nursing Day shift 7a-3p 1 Unit Manager& Desk Nurse 3 Nurses 8 CNA's Avg. Census:59 Nursing Evening Shift 3p-11p Desk Nurse 3p-7p 2 nurses 7 CNA's Avg. Census: 59 Nursing Night Shift 11p-7a 2 nurses 5 CNA's Avg. Census:59 During an interview with the surveyor on 04/29/2024 at 01:11 PM, the U.S. FOIA (b)(6)) was asked what the facility staffing plan is for the 1st and 2nd floor. The U.S. FOIA (b) replied with the following: 1st floor 7a-3p shift 1 desk nurse, 1 Unit Manager (UM), 3 nurses and 5-7 CNA's pending census. 3p-11p shift Nurse 12-hour shifts and there are 3 until 7PM then goes to 2 nurses at 7PM, 5-6 CNA's pending	F 725		

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F 725	Continued From page 20 census. 11p-7a shift 2 nurse 1 supervisor and 4 CNA'S. 2nd floor 7a-3p shift 1 desk nurse 1 UM 3 nurses and 7 CNA'S. 3p-11p shift Nurse 12-hour shifts and there are 3 until 7PM then goes to 2 nurses at 7PM, and 6 CNA'S. 11p-7a shift 2 nurses, 1 supervisor, 4 CNA'S. The surveyor asked if this is daily, including weekends? The [redacted] replied, "No, we don't have UM's on the weekends, but we do have a desk nurse. When asked are you meeting this plan, the [redacted] replied "No."	F 725		
F 812 SS=E	NJAC 8:39-5.1(a), 27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812		5/25/24

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F 812	Continued From page 21 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 4/23/2024 from 09:23 to 10:04 AM, the surveyor, accompanied by the[redacted] observed the following in the kitchen: 1. In the dry storage room on a middle shelf a quarter pan contained (7) bottles of [redacted] Breakfast syrup. (6) bottles had a "best if used by" date of Nov 09 2023. The [redacted] removed the expired syrups from storage. 2. In the walk-in freezer on a middle shelf a plastic bag contained frozen hash brown potatoes. The product inside the bag was covered in ice. The bag had no dates. The [redacted] removed the frozen hash browns to the trash. On a lower shelf a box contained frozen French fries. The bag of French fries was opened and exposed to the air. The [redacted] removed the bag of French fries to the trash.	F 812	F812-Food Procurement, Store/Prepare/Serve-Sanitary 1. As stated in deficiency report all undated foods (syrup & potatoes were discarded immediately by FSD) The corrective action will ensure that all residents are served food that was stored, prepared, and distributed with professional standards for food safety. 2. Due to the potential of all residents being effected he following procedures have been implemented to ensure the safety of the residents and that they will not be affected by the same deficient food storage practices immediately & in the future. 3. Food Storage Audits will be conducted weekly by management staff (FSD, AFSD & or Dietician) These audits will be part of our QAPI reports and we will use them to identify any laps in food storage or procurement. 4. Daily food storage checklist was created and be completed nightly by Dinner Chef or ASFD 5. To ensure that the deficient practice is	

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	315421	A. BUILDING _____ B. WING _____	C 05/08/2024

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F 812	Continued From page 22 A review of a facility policy titled Dating and Labeling Policy, Est: 12.22. revealed: "All Cambro (An insulated container for keeping food or drink hot), plastic wrapped, or and foods otherwise stored outside their original containers, must be labeled, and dated at the time it (sic) put into its container. The label must include the item description, the date stored and the use by date. All items are to be dated with an expiration date of 5 days unless otherwise specified." "All kitchen staff are responsible for labeling items as they are opened and stored as they work. All dates and labels are monitored and verified at the end of each service day by the Prep cooks and Cooks on duty to ensure items have been dated properly, used by their Use-By-Date, or discarded if necessary."	F 812	corrected a root cause analysis was completed which identified gaps in staff education and staff oversight. The systemic changes that have been made include the following: 6. The new procedure was added to the Policy and Procedure manual. The FSD has added the inspection results to their monthly QA report. The result of the audits will be presented at the monthly performance improvement meeting for review and recommendations. The QAPI team meets quarterly, and the FSD will provide a copy of the report to the Administrator. The QAPI committee will determine the need for continued monitoring.	
F 880 SS=D	NJAC 18:39-17.2 (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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:	F 880		7/1/24

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F 880	Continued From page 23 §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 §483.70(e) 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, 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.	F 880		

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F 880	Continued From page 24 §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, review of the medical record and other facility documentation, it was determined that the facility failed to a) change NJ Exec Order 26.4b1 equipment NJ Exec Order in a manner to prevent the spread of NJ Exec Order 26.4b for 1 of 4 resident's (Resident #33) and b) properly store a NJ Exec Order 26.4b1 in accordance with facility policy and not properly store a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 equipment according to facility policy for 1 of 4 residents (Resident #91) reviewed for NJ Exec Order 26.4b1 care. This deficient practice was evidenced by the following: A) During the initial tour of the 2nd floor on 04/23/2024 at 09:53 AM, Surveyor #1 observed resident #33 sleeping in bed. Resident #33 was receiving Ex Order 26.4B1 . Surveyor #1 observed the Ex Order 26.4 Ex Order 26.4B1 with a piece of tape attached to the NJ Exec Order 2 and dated Ex Order 26.4B1.	F 880	Plan of Correction: 2024 Survey Effective date: May 9, 2024 F880 – Infection Prevention and Control 1. 2 residents (#33 and #91) were mentioned in F880. The NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 was immediately changed and dated. The NJ Exec Order 26.4b1 was stored in a new plastic bag. An immediate audit was conducted to check all and NJ Exec Ord masks being used in building for accuracy in labeling. All labelled appropriately. 2. All residents using oxygen and Nebulizer treatments have the potential to be affected by the deficient practice. 3. To ensure that the deficient practice is corrected, a root cause analysis was completed which identifies gaps in staff education, oversight. The systemic changes that have been made include the following: a. Staff Education – the nurses were educated via in-service about checking on o2 tubing and nebulizer masks during	

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F 880	Continued From page 25 According to the Admission Record, Resident #33 was admitted to facility with diagnoses including but not limited to: Ex Order 26.4B1 [redacted] According to the most recent Minimum Data Set (MDS), an assessment tool dated Ex Order 26.4B1, Resident #33 had a Brief Interview for Mental Status score of [redacted] indicating Ex Order 26.4B1 Ex Order 26.4B1 . A review of the Physician Orders with active orders as of Ex Order 26.4B1 revealed a physician order to administer Ex Order 26.4B1 [redacted] continuous for Ex Order 26.4B1 . The Physician Orders also included a physician order to "change and date Ex Order 26.4B1 tubing weekly, every week on Saturday at 7:00pm - 7:00am." On 04/25/2024 at 11:07 AM, Resident #33 was observed in bed NJ Exec Order 26.4b1. Resident #33 was receiving Ex Order 26.4B1 [redacted] Surveyor #1 observed the Ex Order 26.4B1 Ex Order 26.4B which revealed it was dated Ex Order 26.4B1 [redacted] 04/26/2024 at 10:31 AM, Surveyor #1 observed resident #33 in bed sleeping. Resident #33 was receiving Ex Order 26.4B1 Ex Order 26.4B1 Surveyor #1 observed the Ex Order 26.4B1 Ex Order 26.4B which revealed it was dated Ex Order 26.4B1 During an interview with Surveyor #1 on 04/26/2024 at 10:45 AM, Licensed Practical	F 880	daily (every shift) walking rounds/shift report and the importance of ensuring that the tubing is being appropriately used, dated and when not in use, appropriately stored in plastic bag. A list of residents using o2 and Nebulizers will be part of report. A daily log will be maintained by the nurses, every day during walking rounds/shift report. b. When checking, ensure date reflects date from last Saturday as that's the day the O2 tubing and nebulizer masks are to be changed per policy. Discard all old tubing and replace with new tubing if labelling does not reflect past Saturday's date. c. As a dual check, the Aides were educated via in-service about checking on o2 tubing and nebulizer masks when in room rendering care. The importance of ensuring that the tubing is being appropriately used and when not in use, appropriately stored. d. Increased Oversight – the unit manager will conduct rounds and review the logs daily. The IP (on weekday) and supervisor (on weekends) will conduct weekly audits for 1 month then monthly audits for 3 months to reinforce the task. 4. To ensure that the deficient practice is being corrected and will not recur, is by direct oversight of the IP (on weekday) and supervisor (on weekends) by conducting weekly audits for 1 month then bi-monthly audits for 1 month thereafter. A written report will be completed and reviewed with the Director of Nursing and/or Clinical Care Administrator. In addition, the Administrator in Training will	

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F 880	Continued From page 26 Nurse (LPN #1) was asked how often [redacted] gets changed. LPN #1 responded, "The [redacted] is to be changed every week and as needed." Surveyor #1 asked who is responsible to change the [redacted]. LPN #1 said the nurse on the overnight (7 pm - 7am) shift. Surveyor #1 then asked should the [redacted] remain on the [redacted] past seven days. LPN #1 stated, "No, it should be changed weekly as ordered." During an interview with Surveyor #1 on 04/29/2024 at 09:52 AM, the [redacted] said [redacted] is to be changed weekly on Saturdays by the overnight nurse. When asked should the [redacted] remain on the [redacted] past seven days, the [redacted] said no it should be changed weekly. During an interview with Surveyor #1 on 04/29/2024 at 1:19 PM, the [redacted] said that the [redacted] gets changed every Saturday on the overnight shift. The [redacted] went on to say that [redacted] should not remain on the [redacted] past the seven days for [redacted] control purposes. B. On 04/23/2024 at 10:26 AM, during the initial tour of the facility, Surveyor #2 observed Resident #91 seated in their wheelchair in their room. Surveyor #2 observed an [redacted] machine next to the bedside table behind Resident #91, and the [redacted] draped was over the trash can next to Resident #91's bed with the [redacted] inside the trash can. The [redacted] was turned on at the time and was set at [redacted]. In addition,	F 880	continue the QAPI plan specific for the O2, Nebulizer masks for 3 months. The findings will be reported to the Administrator and to the QAPI committee quarterly who will determine the need for continued monitoring.	

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F 880	Continued From page 27 observation of the bedside table revealed a Ex Order 26.4B1 lying on top of bedside table attached to a Ex Order 26.4B1 machine. The NJ Exec Order 26.4b1 [redacted] was exposed while not in use with face side facing up. When asked by Surveyor #2 , Resident #91 agreed that he/she utilized Ex Order 26.4B1 Ex Order 26.4B1. According to the Resident Face Sheet, Resident #91 was admitted to the facility with diagnoses including but not limited to: Ex Order 26.4B1 [redacted] A review of the most recent MDS, an assessment tool, Resident #91 had a Brief Interview for Mental Status score of Ex Order 26.4, indicating Ex Order 26.4B1 Ex Order 26.4B1 According to Section NJ Resident #91 had active diagnoses of Ex Order 26.4B1 [redacted] Section NJ B indicated that Resident #91 received continuous Ex Order 26.4B1. A review of the Physician's Orders, revealed the following orders for Resident #91: 1. Ex Order 26.4B1 [redacted]) continuous. Every Day at 7:00 am - 7:00 pm; 7:00 pm - 7:00 am. Original order date: 03/12/2024." 2. Ex Order 26.4B1 [redacted]	F 880		

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F 880	Continued From page 28 times per day. Every Day at 9:00 am; 1:00 pm; 5:00 pm. Original Order Date: NJ Exec Order 26.4b1 ." A review of the April 2024 Medication Administration Record (MAR) for Resident #91 revealed that Resident #91 received continuous Ex Order 26.4B1 on NJ Ex Order 26.4b1 at 7:00 am to 7:00 pm and a Ex Order 26.4B1 on NJ Ex Order 26.4b1 at 9:00 am, as indicated by nursing documentation. During an interview with Surveyor #2 on 04/30/2024 at 09:38 AM, Registered Nurse (RN#3) assigned to Resident #91, was asked if it was facility practice to allow a resident's Ex Order 26.4 to be suspended in the trash can and to allow a Ex Order 26.4B1 to be exposed when not in use. RN#3 responded, "He/she constantly plays with his/her stuff. They are on NJ Exec Order 26.4b1 so it should not be off. But it shouldn't have been in the trash can for sure. I'll have to talk to him/her." Surveyor #2 then asked if the Ex Order 26.4B1 should be left exposed when not in use. RN #3 stated, "The Ex Order 26.4B1 when not in use should be covered for infection control." During an interview with Surveyor #2 on 04/30/2024 at 10:03 AM, the US FDA (b) stated, "The Ex Order 26.4B1 should be bagged between uses for infection control purposes. It is the responsibility of the nurse or helping hands staff can assist." A review of a facility policy titled Oxygen Administration undated, revealed under the heading NOTE: 6. Infection control procedures shall be followed: No oxygen cannulas or tubing touching the floor. Nasal cannulas shall be changed weekly or more	F 880		

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F 880	Continued From page 29 often, if necessary. Cannulas, masks, or other respiratory equipment will be covered by plastic bags when not in use. NJAC 8:39-19.4(k)	F 880		

New Jersey Department of Health

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to maintain the reuired minimum direct care staff to resident ratios as mandated by the StateofmNew Jersey. This was evident for 1.) 07/30/2023 to 08/12/2023, the facility was deficient in Certfied Nursing Assistants (CNA) staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts and 2.) 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts.	S 560	Plan of Correction: 2024 Survey Effective date: May 16, 2024 S560 – Mandatory Access to Care 1. No residents were affected by the deficient practice. 2. All residents have potential to be affected by the deficient practice. 3. To ensure that the deficient practice is corrected, a root cause analysis was completed which identifies Direct care staff to Resident ratio isn't met. The systemic changes that have been made include the following: a. Increase Pay rate to retain current	5/16/24

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

Electronically Signed | 05/24/24

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S 560	Continued From page 1 Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During the initial tour on 04/23/2024 at 10:30 AM, Resident #32 was just getting AM care. Resident #32 said they are short of nurses and aides all the time, especially on weekends. 04/23/24 10:30 AM Resident #72 stated that they do not have enough aides on the weekends. Resident also stated that he/she did not receive [redacted] yesterday due to being short staff. 1. For the 2 weeks of Complaint staffing from 07/30/2023 to 08/12/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for	S 560	Staff and attract new staff. b. Sign-On Bonus for C N A. c. New Resident Helping Hand (RHH) position to assist C NA with bed making, transport, tidy up rooms, answer call lights. d. Dining Assistant Training to train staff to assist with feeding residents. e. Sponsor Students for C N A training. f. Therapists assist with ADLS for subacute residents. g. Nurses take C N A assignments. h. Contract with 5 Staffing Agencies to provide contracted CNAs. 4. To ensure that the deficient practice is being corrected and will not recur, there will be direct oversight of the Director of Nursing and/or Clinical Care Administrator to meet required standards by reviewing Staffing schedule daily for 1 month. Thereafter the Director of Nursing and/or Clinical Care Administrator will check every week for 1 month to ensure compliance. The findings will be reported to the Administrator and to the QAPI committee who will determine the need for continued monitoring. Completion date: July 16, 2024	

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S 560	Continued From page 2 residents on 1 of 14 overnight shifts as follows: -07/30/23 had 8 CNAs for 114 residents on the day shift, required at least 14 CNAs. -07/30/23 had 7.5 total staff for 114 residents on the overnight shift, required at least 8 total staff. -07/31/23 had 11 CNAs for 113 residents on the day shift, required at least 14 CNAs. -08/01/23 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/02/23 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/03/23 had 9 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/04/23 had 9.5 CNAs for 112 residents on the day shift, required at least 14 CNAs. -08/05/23 had 8.5 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/06/23 had 10.5 CNAs for 115 residents on the day shift, required at least 14 CNAs -08/07/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/08/23 had 9 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/09/23 had 10 CNAs for 115 residents on the day shift, required at least 14 CNAs. -08/09/23 had 10.5 total staff for 115 residents on the evening shift, required at least 11 total staff. -08/10/23 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. -08/11/23 had 9.5 CNAs for 118 residents on the day shift, required at least 15 CNAs. -08/12/23 had 9.5 CNAs for 116 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of staffing prior to survey from 04/07/2024 to 04/20/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts, deficient in total staff for residents on 2	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061511	A. BUILDING: _____ B. WING _____	C 05/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN NURSING AND REHABILITATI(	1579 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 of 14 evening shifts, deficient in CNAs to total staff on 2 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -04/07/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -04/08/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/09/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/11/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/12/24 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -04/13/24 had 7.5 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/14/24 had 8.75 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/14/24 had 10.5 total staff for 107 residents on the evening shift, required at least 11 total staff. -04/14/24 had 4.5 CNAs to 10.5 total staff on the evening shift, required at least 5 CNAs. -04/15/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/16/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/17/24 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/18/24 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/19/24 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -04/19/24 had 9 total staff for 107 residents on the evening shift, required at least 11 total staff. -04/19/24 had 6 total staff for 107 residents on the overnight shift, required at least 8 total staff. -04/20/24 had 7.75 CNAs to 16.25 total staff on the evening shift, required at least 8 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 During an interview with the surveyor on 04/26/2024 at 9:45 AM, Registered Nurse #1 said we are challenged a lot for staff, we have call outs. When asked about weekends she replied I don't do weekends. We try to have at least 1 desk nurse on the weekend as back up for call outs. Also, if you call out on the weekend you have to make it up. During an interview with the surveyor on 04/26/2024 at 11:02 AM CNA#1 said, "We are always short. We have 3 aides today and I have like 19 residents." When asked how is staffing on weekends, CNA #1 said, "I work every other weekend and we are always short on weekends." When asked how many aides should you have, CNA #1 replied, "We are supposed to have 8 aides but may have the same as today. There are no hospice aides to help on the weekends." During an interview with the surveyor on 04/29/2024 at 10:15 AM, the Staffing Coordinator said she was aware of the minimum staffing requirements for CNA's which is 1 to 8 residents for 7-3 shift, 1 to 10 for 3-11 shift and 1 to 14 for 11-7 shift. When asked if the facility meets those requirements, the Staffing Coordinator said "No." A review of a facility policy titled Nurse Staff Mandatory did not include the mandated minumum requirements for staffing.	S 560		
S1160	8:39-13.4(c)(3) Mandatory Communication (c) At least one education training program each year shall be held for all employees on each of the following topics:	S1160		7/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1160	Continued From page 5 3. Resident rights; and This REQUIREMENT is not met as evidenced by: Based on interview and review of facility employee in-service education records, it was determined that the facility failed to provide evidence that Certified Nursing Assistants (CNAs) received annual inservice training on the mandatory topic of Abuse and Neglect, Resident Rights, Emergency Preparedness, and Dementia Care. This deficient practice was identified for 2 of 5 CNA education files reviewed, and was evidenced by the following: The surveyor requested five (5) random CNA education files for the calendar year of 2023. A review of two (2) of five (5) education files did not include documentation that CNA #3 and CNA #4 received annual training for Abuse and Neglect, Resident Rights, Emergency Preparedness and Dementia Care. During an interview with the surveyor on 04/26/2024 at 10:26 AM, the Director of Nursing (DON) was asked if there are mandatory yearly education training's staff are required to complete? The DON replied, "We have list of topics and will get them for you." The DON was asked who is responsible to ensure that the required educations are completed? The DON responded, "What happens is [company name] which is our computer training, they send the employee a message that the education is due. We tell staff we will take them off the schedule if not complete. The Assistant Director of	S1160	Plan of Correction: 2024 Survey S1160 – Mandatory Communication 1. No residents were affected by the deficient practice. 2. All residents have potential to be affected by the deficient practice. 3. To ensure that the deficient practice is corrected, a root cause analysis was completed which identifies gaps in Annual Staff Mandatory Training. The systemic changes that have been made include the following: a. The mandatory training will be opened for completion 3 months prior to due date/Date for Annual Evaluation. b. Reminders will be sent to Staff via “voice friend” platform, 3 months prior to their due date/Date for Annual Evaluation for completion of Mandatory Training. c. In the month of Annual Evaluation, Clinical Care Administrator will ensure that the Mandatory Training requirements are completed by the Staff member. d. Once Mandatory Training is completed by the Staff member, the Unit Manager will be informed, after which the manager will proceed with Staff Annual Evaluation. 4. To ensure that the deficient practice is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1160	Continued From page 6 Nursing/Minimum Data Set coordinator and I tell the staff in the nursing/aide meeting they need to get them done or do it in the meeting." The DON also said the company sends staff a reminder and we have someone in house who reminds the supervisor that the staff needs to complete the education. A review of a facility policy titled Mandatory Training with reviewed date of 1/20/2024 revealed under the policy section: "It is the policy of [facility name] to provide our mandatory manual upon hire. In-services and training are provided as needed. All staff must complete mandatory [computer company name] on an annual basis." A review of a facility provided Mandatory Training Manual indicated a list of the educations. The list included but was not limited to; Abuse Policy/Reporting Abuse, Resident Rights, Emergency Preparedness, and Dementia Care.	S1160	being corrected and will not recur, is by direct oversight of the Clinical Care Administrator (CCA). CCA will report weekly for 1 month and then bi-monthly x 1 month to Director of Nursing. The findings will be reported to the Administrator and to the QAPI quarterly committee who will determine the need for continued monitoring. Completion date: July 1, 20	

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
315421 Y1	A. Building B. Wing Y2	7/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN NURSING AND REHABILITATION CENTER	1579 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

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 F0582	Correction	ID Prefix F0658	Correction	ID Prefix F0695	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(i)	Completed
LSC	05/25/2024	LSC	07/01/2024	LSC	07/01/2024
ID Prefix F0725	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/01/2024	LSC	05/25/2024	LSC	07/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/8/2024	☐ 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
315421 Y1	A. Building B. Wing Y2	7/3/2024 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0004	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/25/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061511 Y1	A. Building B. Wing Y2	7/3/2024 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/16/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
5/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S1160	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-13.4(c)(3)	Completed	Reg. #	Completed
LSC	05/16/2024	LSC	07/01/2024	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	
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	
5/8/2024	☐ 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
	315421	A. BUILDING **02** B. WING _____	**05/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 05/07/2024 and 05/08/2024, and Rose Garden Nursing and Rehabilitation 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 Occupancy Rose Garden Nursing and Rehabilitation Center is a 2-story building that was built in April 2005, It is composed of Type II Protected Construction. The facility is divided into 4- smoke zones. The facility has one Diesel 150 KW (Kilowatt) Emergency Generator. The census was 111 Residents at the time of survey.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 05/07/2024 and 05/08/2024, in the presence of the facility management, it was determined that	K 345	2024 Survey - Plan of Correction Effective: 5.8.24 K345- Fire Alarm System	5/20/24

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

Electronically Signed | 05/24/2024

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 345	Continued From page 1 the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following: On 05/07/2024 during the survey entrance at approximately 8:20 AM, a request was made to the US FOIA (b)(6)) to provide all mandatory inspections from the last Re-Certification survey of 01/03/2022 to 05/07/2024 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later at approximately 11:50 AM, a review of the facility provided mandatory inspections for the previous 28 months identified was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections as follows: - 04/10/2024 quarterly inspection. - 01/29/2024 quarterly inspection. - 10/05/2023 quarterly inspection. - 07/06/2023 quarterly inspection. - 04/11/2023 quarterly inspection. - 01/06/2023 quarterly inspection. - 10/03/2022 quarterly inspection. - 07/07/2022 quarterly inspection. - 04/12/2022 quarterly inspection. - 01/14/2022 quarterly inspection.	K 345	1. No residents were affected by the deficient practice. 2. All residents had the potential to be affected by the deficient practice. 3. To ensure the deficient practice was corrected a root cause analysis was completed which identified gaps in staff education. The DOM- Director of Maintenance received education on smoke detection sensitivity testing from the Administrator. a. On 5.8.24, Associated Fire was contacted, sensitivity testing was scheduled and completed. b. On 5.9.24, Associated Fire conducted sensitivity testing; certificate of completion was received. c. Sensitivity testing was scheduled annually to assure the facility remains in compliance with NFPA 72- National Fire Alarm and Signaling Code. Next inspection date was scheduled for May 2025. 4. Smoke detection sensitivity has been scheduled annually for QA. 5. The DOM will maintain the documentation of completion in the facility life safety manual and will assume the responsibility for assuring the facility remains complaint with sensitivity testing. 6. To ensure that the deficient practice is being corrected and will not recur, the dates and results of the sensitivity testing will be reported to the QAPI committee. The QAPI committee meets quarterly, and the DOM will provide a copy of the report to the Administrator. The QAPI committee will determine the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. BUILDING **02** B. WING _____	**05/08/2024**

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

(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 345	Continued From page 2 The review of the testing reports revealed no reference to a smoke detection sensitivity testing. On 05/07/2024 at approximately 1:20 PM, a request was made to the [US FOIA] that the facility may have to place a telephone call to the [US FOIA (b)(6)] for the Fire Alarm and Detection System and request to get a copy of the last smoke detector sensitivity testing. On 05/08/2024 at approximately 9:07 AM, during an interview with the facility [US FOIA] the surveyor asked if the facility had obtained a copy of the last smoke detector sensitivity testing. The [US FOIA] told the surveyor that the [US FOIA] had not conducted the smoke detector sensitivity testing. The smoke detector sensitivity testing of the fire alarm and detection system had not been done. The facility [US FOIA] confirmed the finding at the time of review and interview. The surveyor informed the [US FOIA (b)(6)] of the Life Safety Code deficiency on 05/08/2024 at approximately 12:01 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10	K 355		5/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315421	A. BUILDING **02** B. WING _____	**05/08/2024**

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K 355	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 05/07/2024 and 05/08/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 2 of 21 portable fire extinguishers observed and inspected. as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following,	K 355	2024 Survey - Plan of Correction Effective: 5.8.2024 K355- Portable Fire Extinguishers 1. All residents had the potential to be affected by the deficient practice. 2. No residents were affected by the deficient practice. 3. To ensure the deficient practice was corrected, that monthly visual examinations on all fire extinguishers are performed, a root cause analysis was completed which identified gaps in staff education and compliance. The following corrections were made: a. The P&P for checking fire extinguishers was updated to include 22 handheld ABC fire extinguishers throughout the facility and 1 K rated handheld fire extinguisher located in the kitchen. b. The Maintenace Department was in serviced on the updated P&P c. All facility fire extinguisher housing stations/cabinets have been labeled numerically to ensure no fire extinguisher is missed during the monthly inspections. d. June and July inspections will be completed by the maintenance technician with the DOM at his side to assure compliance with new P&P. e. DOM will do random spot checks for continued QA. f. A portable Fire Extinguisher Log was created and will be utilized when completing monthly rounds, assuring that no fire extinguisher is missed. 4. To ensure that the deficient practice is	

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K 355	Continued From page 4 On 05/07/2024 (day one of survey) during the survey entrance at approximately 8:220 AM, a request was made to the US FOIA (b)(6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with 66 Resident sleeping rooms. Starting at approximately 9:10 AM on 05/07/2024 and continued on 05/08/2024, in the presence of the facility's US FOIA a tour of the building was conducted. Along the two (2) day tour the surveyor observed and inspected twenty-one (21) fire extinguishers in various locations that were last annually inspected February 2024 with the following issues that were identified: On 05/07/2024: 1) At approximately 11:06 AM, One (1) "ABC-Type" fire extinguisher inside the first floor Elevator Mechanical room was last annually inspected February 2024. There was no evidence that a monthly visual examination was performed and documented on the tag attached to the extinguisher for March and April 2024. 2) At approximately 11:36 AM, One (1) ABC-Type fire extinguisher inside the Commercial laundry room last annually inspected February 2024. There was no evidence that a monthly visual examination was performed and documented on the tag attached to the extinguisher for March and	K 355	being corrected and will not recur, the maintenance department will be responsible for checking all potable fire extinguishers monthly. All fire extinguishers will be initialed and dated for QA. The Portable Fire Extinguisher Log will be completed monthly and presented at the monthly performance improvement meeting for review and recommendations. The QAPI team meets quarterly, and the DOM will provide a copy of the report to the Administrator. The QAPI committee will determine the need for continued monitoring. Completion date: 5.25.2024	

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K 355	Continued From page 5 April 2024. The facility US FOIA [redacted] confirmed the findings at the time of observations. The surveyor informed th US FOIA (b)(6) [redacted] f the Life Safety Code deficiency on 05/08/2024 at approximately 12:01 PM.	K 355		
K 761 SS=D	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e). Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 05/07/2024 and 05/08/2024, in the presence of facility Management, it was determined that the facility failed to ensure that 1 of 5 exit access 3/4 hour fire rated stairwell doors tested, functioned properly and were capable of	K 761	2024 Survey - Plan of Correction Effective: 5.8.2024 K761 Maintenance, Inspection &Testing Doors 1. The deficient practice was identified and had the potential to affect 50	5/25/24

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K 761	Continued From page 6 maintaining the 1 hour fire rated construction. This deficient practice was identified and had the potential to affect 50 Residents who reside on the second floor of the facility, and was evidenced by the following: On 05/07/2024 (day one of survey) during the survey entrance at approximately 8:220 AM, a request was made to the US FOIA (b)(6) , to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with 66 Resident sleeping rooms. There are three (3) interior stairwells that Residents, Visitors and Staff could use in the event of an emergency from the second floor. Starting at approximately 9:10 AM on 05/07/2024 and continued on 05/08/2024 in the presence of the facility's US FOIA a tour of the building was conducted. During the two day tour of the building the surveyor inspected and conducted closure test of five (5) exit access doors leading into exit stairways with the following results, On 05/07/2024 at approximately 10:23 AM, during a closure test of the second floor (2nd) floor stairway, (next to Resident room #220) corridor exit access door, when the door was opened to a 90 degree opening to the door frame and allowed to self-close, the door did not positive latch into its frame. This test was performed two additional times with the same results. The surveyor observed the door latching device	K 761	residents who reside on the second floor of the facility. 2. No residents were affected by the deficient practice. 3. At the time of the survey when the deficient practice occurred the following intervention was immediately completed: On 5.8.24 the DOM- Director of Maintenance made adjustments to realign the latch assembly that was noted to be of concern. With the adjustment the door positive latch into its frame and the door latching device did not stop short of the door□s frame keeper; properly latching into its frame. 4. The DOM completed an audit and confirmed that all stairwell doors are currently functioning properly. 5. P&P for Monthly Door Maintenance, Inspection and Testing was updated to include the location of the 5, ¿ smoke doors and to ensure the 5 doors positive latch. 6. The Maintenance Department was in serviced on the updated P&P 7. The June and July inspections will be completed by the maintenance technician with the DOM at his side to assure compliance with new P&P. 8. DOM will do random spot checks for continued QA. 9. The result of the audits will be presented at the monthly performance improvement meeting for review and recommendations. The QAPI team meets quarterly, and the DOM will provide a copy of the report to the Administrator. The QAPI committee will determine the need for continued monitoring.	

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K 761	Continued From page 7 stopped short of the door frames keeper and did not positive latch into its frame. A review of an emergency evacuation diagram posted in the corridor identifies that stairwell as the primary exit to reach an exit discharge door. The stairwell doors would need to positive latch into its frame to maintain the 3/4 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The [redacted] confirmed the finding at the time of observations. The surveyor informed the [redacted] of the Life Safety Code deficiency on 05/08/2024 at approximately 12:01 PM. Fire Safety Hazard.	K 761	Completion date: 5.25.2024	
K 918 SS=E	NJAC 8:39- 31.2(e) Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40	K 918		6/19/24

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K 918	Continued From page 8 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/07/2024 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was identified and had the potential to affect 111 Residents who reside in the facility, and was evidenced by the following: On 05/07/2024 (day one of survey) during the survey entrance at approximately 8:20 AM, a request was made to the US FOIA (b)(6) [redacted] if the facility had an Emergency Generator.	K 918	2024 Survey - Plan of Correction Effective: 5.8.24 K918- Electrical Systems 1. No residents were affected by the deficient practice. All residents had the potential to be affected by the deficient practice. 2. Upon inspection it was noted that the facility's emergency generator did not have a remote emergency stop button installed that is mounted away from the generator. a. The maintenance director requested proposals for installation of this remote emergency stop button from the electrical	

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K 918	Continued From page 9 The US FOIA told the surveyor, yes we have one (1) 150 KW (Kilowatt) Diesel Emergency Generator. Starting at approximately 9:10 AM on 05/07/2024 in the presence of the US FOIA a tour of the building was conducted. During the building tour the of the facility at approximately 11:29 AM, an inspection outside of the building where the Emergency Generator is located was performed. The surveyor observed that the 150 KW Diesel Emergency Generator had the Stop button located on the control panel of the generator. The surveyor observed no evidence of remote Stop button for the 150 KW Diesel Emergency Generator. At that time the surveyor asked the US FOIA "Do you have a remote stop button for the generator." The US FOIA told the surveyor, no. The US FOIA confirmed the findings at the time of observation. The surveyor informed the US FOIA (b)(6) of the Life Safety Code deficiency on 05/08/2024 at approximately 12:01 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	contractor and generator service company. b. Once the proposal was given by the contractor and electrician, parts were ordered, and the installation of the remote emergency stop button was scheduled to be installed on 6.19.2024. c. The maintenance director ordered a notification sign for the emergency stop button and a sign was placed in close vicinity to the emergency stop button after installation. d. All US FOIA (b)(6) were in serviced on the location of the remote emergency stop button. 3. The DOM or designee will store the records of the installation of the facility generator emergency stop button on site. DOM updated the checklist for weekly inspections of the emergency back-up generator to included checking the remote e stop cover for damage. In addition, the facility's generator service vendor will test the function and placement of the remote stop button during their quarterly inspections. 4. Results of the findings will be evaluated and reported monthly to the QAPI committee by the DOM or designee. The QAPI committee meets quarterly and will determine if the continuation of monitoring or any other actions are needed as a result of continued	

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K 918	Continued From page 10	K 918	compliance. Attachment: Generator Checklist	

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
315421 Y1	A. Building 02 - ROSE GARDEN B. Wing Y2	7/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE GARDEN NURSING AND REHABILITATION CENTER	1579 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

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 K0345	05/20/2024	LSC K0355	05/25/2024	LSC K0761	05/25/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	06/19/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/8/2024	☐ YES ☐ NO