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 _____	01/03/2022

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
F 000	INITIAL COMMENTS Standard Survey: 1/3/2022 Census: 101 Sample: 21+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of documentation provided by the facility, it was	F 812	Plan of Correction: 2021 Survey Completion Date: 1/13/2022	1/13/22

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

Electronically Signed | 01/21/2022

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
	315421	A. BUILDING _____ B. WING _____	01/03/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 1 determined that the facility failed to maintain proper kitchen sanitation practices and properly store dry foods in a safe and sanitary environment to prevent the potential development of food borne illness. This deficient practice was evidenced by the following: On 12/17/21 at 09:34 AM, during the initial tour of the kitchen in the presence of the Food Service Director (FSD), the surveyor observed the following: Inside the brown rice storage bin, was a clear scoop resting directly on the rice. The FSD stated that it should not be there due to cross contamination and infection control. The slicer was covered in a clear plastic bag, The FSD removed the clear plastic bag and he noted there was a brown substance and crumbs underneath the blade. He acknowledged that it should not be there due to cross contamination. The FSD stated that the process was to clean the slicer after use and then cover it with a clear plastic bag. There were two Hot Boxes with multiple drip marks and on the inside of both doors. The FSD was able to wipe off a black residue from inside of the doors of the first Hot Box with a paper towel. He was able to wipe off a black residue from inside of the door of the second Hot Box with another paper towel. He stated that the hot boxes were supposed to be cleaned on Thursdays. He acknowledged it was Friday and that it did not look like it was done the day before.	F 812	F812 1. No residents were affected by the deficient practice. The corrective action will ensure that all residents are served food that was stored, prepared, and distributed with professional standards for food service safety. 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 identified gaps in staff education, oversight and a lack of formal policy and procedures. The systemic changes that have been made include the following: a. Staff education - An orientation program for new hires has been established that includes comprehensive training including but not limited to proper kitchen sanitation practices, proper storage, PPE, and hand hygiene. In addition, all dietary employees have been required to complete the Serve Safe Food Handler certification course. Staff education for new and existing staff include quarterly scheduled competencies and in-service training. At the time of survey when the deficient practices occurred the following interventions were immediately completed: the scoop was removed from the brown rice storage bin in the presence of the surveyor. The scoop was then washed, sanitized and properly stored for future use. The slicer was cleaned, disinfected and inspected by the FSD at the time of the finding. The hot	

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	315421	A. BUILDING _____ B. WING _____	01/03/2022

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F 812	Continued From page 2 There were nine cutting boards with multiple stains and gouges: -A large white cutting board with multiple gouges and a black substance. -A large green cutting board with multiple gouges and a black substance. -A large yellow cutting board with multiple gouges and a black substance. -5 small white cutting boards with multiple gouges and a black substance. -A large blue cutting board with multiple gouges and a yellow substance. During an interview with the surveyor at that time, the FSD acknowledged that the cutting boards were worn and should be thrown out. He also stated that the black substance may have been from the cutting board rack holder but should not be there due to possible cross contamination. There were six large spice containers on the shelf above the flat grill that had a clear sticky substance on them. The spices were as follows: -11 ounce (oz) parsley -5 pound ground cumin -26 oz whole basil -26 oz whole basil leaves -12 oz whole Bay leaves -24 oz oregano During an interview with the surveyor at that time, the FSD acknowledged that the containers should not be sticky. The surveyor observed a cook cleaning the slicer. He was wearing a surgical mask with visible facial hair coming out of the bottom of the mask. When the surveyor questioned the cook about the facial hair, he used his bare hand to tuck the hair in the	F 812	boxes were cleaned at the time of the finding in the presence of the surveyor. The kitchen bouquet bottle was thrown away at the time of the finding. The cook whose facial hair extended over his surgical mask replaced his surgical mask with a beard guard at the time of incident. All staff received immediate in-services on proper mask use, beard guards, hair nets and personal hygiene while storing, preparing, distributing or serving food. b. Increased Oversight - In the a.m. the Food Service Director will review and confirm the closing checklist that was completed the previous day to ensure that all sanitation procedures were completed as well as checking that all items are properly labeled. In the absence of the Food Service Director, the morning supervisor will assume the responsibility for cross checking and verifying compliance. The compliance checklists will be returned and preserved in the FSD office where they will be reviewed monthly by the dietitian for ensured compliance. The spices that were not labeled at the time of survey were immediately labeled at that time. c. Policy and Procedure Updates - The policy and procedure manual has been updated and revised to include increasing the frequency of scheduling certain cleaning tasks to daily and to have them recorded on the daily compliance checklist. They include: the cleaning of the hot boxes, cleansing/sanitizing the slicer, cleansing/sanitizing the mixer. In addition, the cleaning protocol for cutting boards has been updated to include a	

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F 812	Continued From page 3 surgical mask and stated that his facial hair is usually contained in the surgical mask. The cook then continued to clean the slicer, without performing hand hygiene. At that time, the FSD instructed the cook to keep his beard contained in the surgical mask or wear a beard guard and to wash his hands and then reclean the slicer. Review of open spices revealed: -16 oz ground cloves with no received date or opened date -16 oz whole thyme leaves with no received date or opened dated -16 oz mild chile powder with a received date 2/4 (no year), no opened date -16 oz Nutmeg with a received date 1/19/21, no opened date -16 oz ground Chipotle chile with no received date, an opened date of 3/21 -16 oz crushed red pepper with a received date 5/5/20, no opened date During an interview at that time with the surveyor, the FSD stated that there should be a received date and opened date on all the containers. He stated that the spices are good for 6 months after they are opened. On a shelf above the stove, there was a hotel pan that contained a kitchen bouquet 32 oz. container that had multiple black dry drips on the outside. The FSD tried to remove the drips with a paper towel but was unable to. He acknowledged that the drips should be wiped as soon as they occurred to prevent cross contamination. There was a 12 oz. Adobe seasoning with no received date, no opened date. Further review of the hotel pan revealed multiple white crystal-like	F 812	monthly cleaning/scrubbing with a specialized cleanser. The cutting boards that were identified as deficient were replaced at the time they were noted. The spices/seasoning containers that were observed to be sticky or had drips were cleaned. To prevent this from recurring the physical storage area and location of spices and seasonings has been changed to ensure that grease and other cooking residue does not cling to the outside of the containers. All spices and seasonings have been placed on a mobile storage cart that is stored in the dry storage room when not in use. Prior to and after the use of the cart it is cleaned and sanitized. Further policy updates include that no pans or spices will be stored above the stovetops. All staff have been in serviced on the policy changes. 4. To ensure that the deficient practice is being corrected and will not recur is by direct oversight of the dietician who will conduct monthly audits and direct observation of kitchen tasks and personal hygiene including but not limited to hair nets, masks, beard guards. A written report will be completed and reviewed with the Food Service Director and Administrator. In addition, the dietitian has started a QAPI plan specific to proper kitchen sanitation practices and proper storage of dry foods in a safe and sanitary environment to prevent the potential development of food borne illness. The QAPI team will meet quarterly and will provide the QAPI report to the Administrator.	

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F 812	Continued From page 4	F 812		

substance on the bottom of the pan. The FSD identified the substance as kosher salt and stated that it should have been cleaned as soon as it was spilled due to cross contamination and that it could alter the salt consistency of a low salt diet if it got into the food being prepared.

There was a mixer covered in a clear plastic bag. When the FSD removed the plastic bag, there was a white substance hanging from the mixer guard. The FSD acknowledged that the substance should not be there due to infection control. He stated that the clear plastic bag indicated that the mixer was clean and ready for use.

During an interview with the surveyor on 12/23/21 at 08:55 AM, the FSD stated that they did not have prior policies for cutting board maintenance, facial hair, or scoop storage.

Review of the Facility's policy "Dating and Labeling Policy", dated 12/15/2020, revealed: Dry storage received date/6-month expiration. 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 Cook on duty to ensure items have been dated properly, used by their Use-By-Date or discarded if necessary. Mixer Cleaning Procedure: 3. Scrub mixer and mixer area with soap and water. 7. When completely dry, cover with a plastic bag. Slicer cleaning instructions: 5. Remove all parts and run them through the machine, 6. Scrub with soap and water. 10. Once slicer is completely dry, Cover with a plastic bag.

NJAC 8:39- 17.2 (g)

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	061511	A. BUILDING: _____ B. WING _____	01/03/2022

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

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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 DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratio as mandated by the state of New Jersey of 1 of 14-day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	S560 Completion Date 1/4/2022 1. No residents were affected by the deficient practice 2. All residents have the potential to be affected by the deficient practice 3. To ensure that the deficient practice is corrected the facility has increased its ad presence on employment sites, social media and the facility website. 4. The Director of Nursing will review and approve of all staffing schedules on a	1/4/22

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

Electronically Signed | 01/21/22

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S 560	Continued From page 1 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 2/01/21: 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 an interview with the surveyor on 12/20/21 at 11:54 AM, the Licensed Practical Nurse Unit manager on the 2nd floor stated there were 8 CNAs assigned for 61 residents on the unit for that day. The surveyor requested staffing for weeks of 11/28/2021 and 12/05/2021. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for 1 of 14 day shifts as follows: -11/28/21 had 9 CNAs for 93 residents on the day	S 560	daily basis to ensure that staffing guidelines are met and maintained. A QA staffing meeting is held with the Administrator, Director of Nursing, Staffing Coordinator and Human Resource Director on a weekly basis.	

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S 560	Continued From page 2 shift, required 13 CNAs. During an interview with the surveyor on 12/22/21 at 11:30 AM, the staffing coordinator stated she was aware of the state staffing ratios and she used an in-house agency to help staff the facility.	S 560		

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	3/25/2022 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 F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/13/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/3/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061511 Y1	A. Building B. Wing Y2	3/25/2022 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 State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/04/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/3/2022	☐ YES ☐ NO

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	315421	A. BUILDING **02** B. WING _____	**01/03/2022**

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**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
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 1/03/2022 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 Occupancies. Rose Garden Nursing and Rehabilitation Center is a two (2) story, Type II Protected building that was built in April 2005. The facility is divided into 4 smoke zones.	K 000		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment.	K 341		2/10/22

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Electronically Signed | 01/21/2022

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	315421	A. BUILDING **02** B. WING _____	**01/03/2022**

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 341	Continued From page 1 Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, and interview in the presence of facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 2 of 2 enclosed outdoor resident areas in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. The deficient practice was evidenced by the following: On 1/03/2022 during the building tour starting at 11:40 AM with the facility Maintenance Director (MD), the surveyor observed two (2) areas that failed to provide fire alarm visual and audio (horn and strobe) notification in the following locations: 1) At 11:46 AM, on the second floor, the surveyor observed that the outside resident patio area did not have any occupant notification devices (horn/strobe tied into the fire alarm system). At that time, the surveyor asked the MD if there was a horn and strobe out in that area to let residents know if there was a fire alarm going on. The MD looked around and said "no." 2) At 1:12 PM, on the first floor, the surveyor observed that the outside enclosed courtyard did	K 341	K341 Completion Date 2/10/2022 1. No residents were affected by the deficient practice. The corrective action will allow individual residents who may be in the outdoor courtyard at the time of a fire emergency to be able to visually and audibly be alerted. 2. All residents who are in an outdoor area have the potential to be affected by the deficient practice in the event of an emergency 3. To ensure that all residents who may be in an outdoor area at the time of a possible fire emergency would be notified, three outdoor fire alarm visual and audio (horn and strobe) systems have been installed in the enclosed outdoor courtyard and on the outside resident patio area. 4. The Director of Maintenance has included the testing and monitoring of the new system in the weekly and quarterly facility	

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 _____	**01/03/2022**

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**

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K 341	Continued From page 2 not have any occupant notification devices (horn/strobe tied into the fire alarm system). The findings were verified and confirmed by the MD during the observations. The Administrator was notified of the findings at the Life Safety Code exit conference at 3:23 PM. NJAC 8:39-31.2(a)	K 341	environmental rounds compliance log. The compliance log is reviewed on a quarterly basis by the fire inspector as part of the Maintenance Department□s QA program.	

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	3/25/2022 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. #	Completed	Reg. #	Completed
LSC K0341	02/10/2022	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	
1/3/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO