STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315384	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Mountain Care Center	Route 1 & 18 New Brunswick, NJ 08901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, it was determined that the facility failed to provide qualified interpreter services for a resident identified as having a language barrier. The deficient practice was identified for 1 of 1 resident (Resident #5) reviewed for language and communication.The deficient practice was evidenced by the following:On 5/13/2026 at 9:32 AM during initial tour, the surveyor observed Resident #5 laying in his/her bed speaking a foreign language later identified as Spanish. The surveyor introduced self to the resident who responded in Spanish. A review of Resident #5's quarterly Minimum Data Set (MDS; an assessment tool) dated 04/30/2026 revealed under section B that Resident #5 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating Resident #5 had moderately impaired cognition. The MDS further revealed under section A, that Resident #5's preferred language was Spanish and that an interpreter was needed to communicate. A review of Resident #5's personalized care plan revealed a focus of potential for difficulty communicating related to language barrier initiated on 04/28/2023, with an intervention to utilize interpreter for native language as needed. On 05/14/2026 at 9:20 AM during an interview Licensed Practical Nurse (LPN) #1 stated that they used Spanish speaking staff to communicate with Resident #5. LPN #1 further stated that the Spanish speaking staff utilized are housekeeping staff and when they were not available, they would contact Resident #5's family member. On 05/14/2026 at 9:30 AM, the surveyor was approached by LPN #1 who showed the surveyor a Visually Speaking board, (a two-sided document that utilized pictures for communication purposes). At that time, LPN #1 stated that if staff was unable to find a staff member or reach the residents family member that they could use the Visually Speaking board. LPN #1 further stated that they have not had to use the board because there has always been a housekeeper around to translate. The surveyor did not observe the Visually Speaking board in Resident # 5's room during any observation. On 05/18/2026 at 1:25 PM during an interview with the surveyor, LPN #2 stated that they utilized Spanish speaking employees to translate for Resident #5. LPN #2 further stated that these employees were not employed as translators but as housekeepers and confirmed that they used housekeeping staff to translate for Resident #5. On 05/19/2026 at 10:31 AM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated that the facility had translators available on the day and evening shifts. The LNHA responded No, when asked if any of the translators were Spanish language translators. The LNHA further stated that the facility used Spanish speaking staff that included housekeeping staff to communicate with Resident #5. When asked by the surveyor if the housekeeping staff should be translating confidential medical information about the resident, the LNHA replied that housekeeping staff does not have the right to the resident's information. A review of the facility provided policy titled Language Barrier/Limited English Proficiency (LEP) Policy revised on 02/01/2026 revealed that the facility will, provide qualified interpreter services when necessary. The policy further revealed that the facility will, Utilize telephone interpreter services, video remote interpretation (VRI), qualified bilingual staff, or approved interpreter services as available. NJAC 8:39-27.1 (a)

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.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, and pertinent facility documentation, it was determined that the facility failed to provide appropriate and sufficient services based upon current standards of practice to document urinary output in the Treatment Administration Record (TAR). The deficient practice was identified for 1 of 2 residents (Resident # 7) investigated for Urinary Catheter.The deficient practice was evidenced by the following:On 05/14/2026 at 9:35 AM, Resident #7 was observed seated in a wheelchair in the Dining Room reading a magazine. At that time Resident #7 stated that he/she had a urinary catheter (tube inserted into the bladder to drain urine) but no longer has one. On 05/18/2026 at 12:37 PM during an interview, the Unit Manager (UM) stated that Resident #7 does have a urinary catheter.A review of the quarterly Minimum Data Set (MDS; An assessment tool) dated 04/16/2026 revealed under section, C that Resident #7 has a Brief Interview for Mental Status (BIMS; a brief assessment to determine cognitive status) of 11, indicating the resident had moderately impaired cognition. Further review of Resident #7's MDS, revealed under section, H that Resident # 7 had an indwelling catheter.A review of the Electronic Medical Record (EMR) under Diagnoses revealed that Resident #7 was diagnosed with but not limited to infection and inflammation reaction due to indwelling urinary catheter.A review of the EMR revealed an active physician's order to monitor urine output every shift with a start date of 09/19/2025.A review of Resident #7's personalized Care Plan revealed a focus of, catheter 16F with 30cc balloon related to obstructive uropathy initiated on 09/03/2025. The focus further revealed a goal to remain patent through next review.A review of Resident # 7's Treatment Administration record for May 2026 revealed blank sections of documentation to monitor output every shift on the following date and shift:05/15/2026: evening shift blank.A review of Resident # 7's Treatment Administration record for April 2026 revealed blank sections of documentation to monitor output every shift on the following dates and shifts:04/05/2026: evening shift blank04/29/2026: night shift blankA review of Resident # 7's Treatment Administration record for March, 2026 revealed blank sections of documentation to monitor output every shift on the following dates and shifts:03/04/2026: night shift blank03/17/2026: night shift blank03/22/2026: day shift blank03/24/2026: night shift blankA review of Resident # 7's Treatment Administration record for February, 2026 revealed blank sections of documentation to monitor output every shift on the following dates and shifts:02/07/2026: night shift blank02/08/2026: night shift blank02/14/2026: night shift blankA review of Resident # 7's Treatment Administration record for January, 2026 revealed blank sections of documentation to monitor output every shift on the following dates and shifts:01/03/2026: night shift blank01/04/2026: night shift blank01/06/2026: night shift blank01/15/2026: night shift blank01/23/2026 evening and night shift blank01/30/2026: night shift blankOn 05/19/2026 at 10:31 AM during an interview with the surveyor, the Director of Nursing (DON) stated that the TAR documentation to monitor output, should not have blank documentation. The DON further stated that this was important so that staff could ensure that the catheter is draining properly. A review of the facility provided undated policy titled Indwelling Urinary Catheter Policy revealed that staff will monitor catheter patency, output and resident tolerance. N.J.A.C. S 8:39-27.1 (a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and review of pertinent facility documents, it was determined the facility failed to ensure an accurate ordering and receiving of narcotic medications on the required Federal narcotic acquisition forms (DEA 222 forms) were completed with sufficient detail to enable accurate reconciliation for 1 of 3 forms provided. The evidence was as follows:On 5/19/2026 at approximately 10:00 AM, the surveyor reviewed the facility provided DEA 222 forms which revealed one of the three provided forms Part 5, had not been completed upon receipt of the medications from the provider pharmacy as instructed on the reverse of the ordering form. The following forms were reviewed:Order form number:260545518-voided260545519- Part 5 was not completed to include number received and date received.260545520- awaiting pharmacy delivery. On 5/19/2026 at 10:51 AM, the surveyor and the Director of Nursing (DON) reviewed the provided DEA 222 forms in the presence of the survey team. The DON acknowledged she should have completed Part 5 as instructed on the reverse of the DEA 222 form as required. A review of the Instructions for DEA Form 222, under Part 5. Controlled Substance Receipt, 1. The purchaser fills out this section on its copy of the original order form. 2. Enter the number of packages received and date received for each line item . A review of the facility Documentation and Inventory of Controlled Substances policy with a revised date of February 2023 included Controlled drugs are inventoried and documented under proper conditions with regard to security and state/federal regulations. NJAC 8:39-29.7(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of pertinent documents it was determined that the facility failed to 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. The deficient practice was identified for 1 of 6 residents (Resident # 89) reviewed under the Infection Control task. The deficient practice was evidenced by the following: On 05/13/2026 at 10:20 AM while in the hallway outside of Resident # 89's room. Outside of the room was a sign that revealed, Stop: Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting . At that time, the surveyor observed a Certified Nurses Aide (CNA) in the room providing care to Resident # 89 who was in bed adjacent to the window. Specifically, the CNA had on clear, disposable gloves on while manipulating the bed linens and removing the trash bag from the room. The CNA was not wearing a protective gown. On 05/13/2026 at 10:21 AM during an interview with the surveyor, the CNA said she does have to wear a gown in the room but stated she was working on the door side of the room. At that time, the surveyor observed the side of the room closest to the door. There was no resident present in that portion of the room, the bed was made and appeared undisturbed. At no time was the CNA working on the door-side of the room during the surveyor's observation. At that time, the CNA left the presence of the surveyor holding a clear plastic bag of trash. A review of Resident # 89's Electronic Medical Record revealed that he/she had a physician's order for Enhanced Barrier Precautions (Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) related to a surgical incision. The order was started on 04/30/2026 A review of Resident # 89's Care Plan revealed that the resident is at increased risk for infection and has a surgical wound requiring enhanced barrier precautions to prevent the spread of infection. A review of the facility provided policy titled, Enhanced Barrier Precautions (EBP) Policy revealed that staff shall wear gloves and an isolation gown during high-contact resident care activities including, but not limited to: Bathing or showering, Dressing, Transferring or repositioning, Toileting assistance, Incontinence care or brief changes, Changing linens or bed making, Wound care, Device care, Providing hygiene care, Assisting with mobility when extensive physical contact is anticipated. The policy revealed under, PPE [Personal Protection Equipment] that Staff shall don gloves and an isolation gown prior to high contact care activities. N.J.A.C. 8:39-19.4(a) Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility staff failed to use appropriate infection control practices specifically with respiratory equipment for 1 of 1 residents reviewed for respiratory care. (Resident #8). The deficient practice was evidenced by the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/18/2026 at 12:41 PM, the surveyor observed Resident #8 being transported via wheelchair into their room by a Certified Nursing Assistant (CNA). The resident was not wearing a nasal canula and did not have oxygen in use. The CNA stated she needed help to transport the client and the oxygen concentrator together, that there was no one to help her at the moment, so she was going to go back to the dayroom to get the concentrator after she settled the resident into bed. At that time the resident's licensed Practical Nurse (LPN) came into the room to check the resident's vitals and overheard the CNA state she was unable to transport the resident and the oxygen concentrator together and offered to retrieve the concentrator from the dayroom while the CNA helped Resident #8 into bed. The surveyor followed the LPN into the day room and observed Resident #8's tubing and nasal cannula attached to concentrator laying across the tablecloth on the dining room table. The LPN and surveyor returned to the room. The LPN took the nasal cannula and tubing and placed it into a plastic bag and proceeded to donn surgical gloves without performing hand hygiene, she then removed the tubing from the plastic bag and was attempting to place the nasal cannula into Resident #8's nostrils when the surveyor stopped the LPN. When the surveyor asked the LPN if that was the same tubing that had been laying exposed on the dining room table the LPN responded that it was. When the surveyor asked when tubing should be replaced and who could replace the tubing, she stated the tubing was changed by nurses every night shift or if it was dirty. The LPN then stated she should probably replace the tubing because it could be contaminated. At that time the surveyor interviewed the CNA who stated there was usually a plastic bag attached to the concentrator where she would place the tubing when not in use, but there was no bag today. The CNA acknowledged she should have discarded the tubing and asked the nurse for new tubing. On 5/19/26 at 10:40 AM, the surveyor interviewed the Director of Nursing (DON) who stated oxygen tubing was changed weekly or if the tubing became contaminated. The DON confirmed Resident #8's oxygen tubing should have been replaced after it had made contact with the dining room table and had potentially become contaminated. A review of Resident # 8's admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to, acute respiratory failure with hypoxia (a life-threatening emergency where the lungs cannot adequately oxygenate the blood) and bronchiectasis (a chronic lung condition where the airways become permanently damaged, widened, and scarred) and adult failure to thrive. A review of Resident # 8's physician's orders revealed orders for O2 (oxygen) 4L (liters) via NC (nasal cannula) continuously every shift Dx: (diagnosis) SOB (shortness of breath); initiated 1/13/2026. A review of the facility's undated Oxygen and Respiratory Equipment Storage policy included Purpose to ensure oxygen tanks, respiratory equipment, and related supplies are stored, handled, maintained, and used safely in accordance with CMS regulations, New Jersey Department of Health requirements, OSHA standards, fire safety regulations, infection prevention guidelines, and manufacturer recommendations. Ensure oxygen tubing and respiratory equipment are maintained in clean and safe condition.Store respiratory medications, nebulizer supplies, and oxygen-related equipment in clean designated areas. NJAC 8:39-19.4(k)(n)