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	10/31/2025

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

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # 2561976Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure residents were protected from neglect after an aphasic, cognitively impaired resident (Resident #1), was left unattended on the outside patio in the heat and sun from approximately 12:50 PM until approximately 3:30 PM on 7/3/25 (two hours and forty minutes). Resident #1 was sent to the hospital, was diagnosed with heatstroke and sustained second degree burns. This deficient practice was identified for 1 of 2 residents, (Resident #1) reviewed for neglect.On 7/3/25 at approximately 12:50 PM, a Certified Nursing Assistant (CNA #1) transported Resident #1 (who was cognitively impaired and required maximal staff assistance with mobility), in a wheelchair to the outside patio on the second floor. CNA #1 did not communicate to other facility staff that Resident #1 was outside on the patio. Resident #1's assigned CNA (CNA #2) nor did any other staff did not check on the resident from 12:20 PM through the end of her shift which was 3:00 PM. At approximately 3:20 PM, Resident #2 and a visitor were on the patio and observed Resident #1 slumped over in their wheelchair. The visitor went back inside the facility and informed a staff member. Resident #1's skin was hot to touch and dry; vital signs were: temperature 103.1 degrees Fahrenheit; heart rate 93 beats per minute; blood pressure 102/64; and respiratory rate of 14. Resident #1 was transferred to the emergency room and presented as lethargic and with a temperature of 104.1 degrees. The resident was diagnosed with dehydration and an elevated troponin (a protein released into the bloodstream when the heart muscle is damaged) and was admitted to the hospital from [DATE] to 7/9/25. The facility's failure to ensure Resident #1 was free from neglect by failing to monitor Resident #1 when they were in an environment of exposure to heat and sun for an extended period posed serious physical harm and impairment to Resident #1 which resulted in an Immediate Jeopardy (IJ) situation. The IJ was determined to be Past Non-Compliance. The IJ began on 7/3/25 at approximately 12:50 PM, after Resident #1 was left unattended in the heat and sun. The facility corrected the immediacy on 7/11/2025, by implementing the following: patio keypad changed from operation from 8 AM to 8 PM to locked; camera installed on the patio; facility wide re-education on Outdoor Resident Policy and Resident Safety/Updated Log Sheets; re-education to CNA #1 and CNA #2; and 30-minute observation checks.The facility's Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 10/31/25 at 5:16 PM. The facility submitted an acceptable Removal Plan (RP) and the survey team verified the implementation of the RP on-site on 10/31/25 during the continuation of the survey.The evidence was as follows:A review of the facility's Abuse Prohibition Policy, dated 3/26/2024, provided by the Assistant Licensed Nursing Home Administrator (AA), included a policy statement that the facility would provide a safe resident environment where residents are free from abuse, neglect, misappropriation of property and exploitation. Abuse was defined by the Code of Federal Regulations (CFR) 483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well being. Neglect, was defined by CFR 483.5 as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful was defined by CFR 483.5, and used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. On 10/31/25 at 9:50 AM, the surveyor observed Resident #1 in bed with their eyes closed. The surveyor was unable to interview Resident #1.A review of the facility initiated Reportable Event Record/Report dated 7/3/25, and completed by the AA revealed: Resident was noted on the patio leaning in [their] wheelchair, resident was brought indoors, and MD (medical doctor) was notified of condition; medics called. Resident was admitted to the hospital for dehydration at 6:55 P. [PM].A review of the investigation provided by the AA revealed statements from CNA #1 explaining that she was in the dining room and brought Resident #1 in a wheelchair to the patio after lunch at approximately 12:50 PM. CNA #1 had not communicated to anyone that Resident #1 was outside. A statement from Resident #2 explained that they were outside on the patio with a guest and saw Resident #1's hand come off the arm rest and the resident slumped forward, and the guest informed the staff. In addition, the investigation revealed CNA #2 was assigned to Resident #1 but there was no written statement from CNA #2. The AA documented CNA #2 was not aware of the resident's whereabouts when the resident finished lunch until the end of CNA #2's shift