STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315509	A. BUILDING _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	**1133 MARLBORO ROAD OLD BRIDGE, NJ 08857**

(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 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		
F 000	INITIAL COMMENTS Complaint #: NJ00165563, NJ00171643, NJ00172586 Survey Date: 8/19/24 to 8/27/24 Census: 166 Sample: 34 + 3 closed records 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		9/20/24

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

Electronically Signed | 09/16/2024

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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F 609	Continued From page 1 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and facility documents, it was determined that the facility failed to report an [redacted] to the New Jersey Department of Health (NJDOH), for 1 of 7 residents (Resident #138), reviewed for accidents. This deficient practice was evidenced by the following: On 08/19/24 at 11:27 AM, during initial tour, the surveyor observed Resident #138 sitting with staff, in the main activity area. The resident was wearing a [redacted]. On 08/21/24 at 09:30 AM, the surveyor reviewed the electronic Medical Record (eMR) for Resident #138 which revealed the following: A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]	F 609	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident # 138 was assessed, [redacted] noted. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The incident related to resident #138 has now been reported to the DOH. Regional nurse educated [redacted]	

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F 609	Continued From page 2 NJ Exec Order 26.4b1. A review of the quarterly Minimum Data Set, an assessment tool dated NJ Exec Order 26.4b1 revealed the resident had a Brief Interview for Mental Status (BIMS) of NJ Exec Order 26.4 indicating the resident was NJ Exec Order 26.4b1. Further review revealed, the resident did not have NJ Exec Order 26.4b1 A review of the Care plan (CP) revealed: "Focus: The resident has a NJ Exec Order 26.4b1 -NJ Exec Order 26.4b1 . Revision on NJ Exec Order 26.4b On 08/21/24 at 12:31 PM, during an interview with Licensed Practical Nurses (LPN) #1 and #2, they both stated that an NJ Exec Order 26.4b1 should be documented, reported to the supervisor(U.S. FOIA (b)(6)) and statements would be taken. A review of the facility provided "NJ Exec Order 26.4b1" report, Dated NJ Exec Order 26.4b1 08:30 revealed: "Incident Description: Nursing Description: Called to room by NJ Exec Order 26.4b1) at approximately 8am, resident noted with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1." Further review revealed a "NJ Exec Order 26.4b1" from LPN #1(who was the assigned nurse at the time)	F 609	US FOIA (b)(6) and all management nurses on reporting and investigating all injuries of unknown origin timely and effectively. DON/ designee educated all nurses, nurses' aides and supervisors on the importance of writing a comprehensive statement for all incidents and accidents of known and or unknown cause. The Facility administrator, DON and IDT team will conduct a comprehensive review of all incidents and accidents in daily clinical meetings to ensure compliance with reporting requirements. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing or designee will audit 3 incident reports weekly x 4 weeks, then monthly x 2 months. Results of the audits will be reported to the Administrator at the quarterly QA meeting.	

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F 609	Continued From page 3	F 609		

"On [redacted] (11-7 shift) this writer observed resident leaning on the table resident was redirected and taken back to bedroom."

A further review of the [redacted] report revealed: "NOTES: [redacted] IDC(Interdisciplinary Care) team met and concluded the following: LTC (Long Term Care) resident with diagnosis of [redacted] With [redacted] Team met to discuss the [redacted] he resident has a potential for [redacted] into furniture/walls when [redacted] on the unit. Will continue to redirect resident as much as possible, and weekly [redacted] to continue. CP reviewed." A review of the additional staff statements did not reveal staff had witnessed a behavior or an occurrence that resulted in the [redacted]

A review of the progress notes revealed: [redacted] 10:19 Nurses Note: Note Text: [redacted] : Called to room at 8am by [redacted] resident sitting by bedside, [redacted] . None [redacted] Notified supervisor on duty, assessed resident in room. ... Incident report initiated ..."

Further review of the progress notes revealed: [redacted] 14:58 Nurses Note: Note Text: [redacted] returned phone call regarding

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F 609	Continued From page 4 unknown [redacted], this writer informed her that the [redacted] .." A review of the physician progress notes revealed: [redacted] 07:49, Physician/NP Note ...Pt (patient) seen and examined. Pt w/ (with recen[redacted] followed by [redacted] in [redacted] status .. [redacted] On 08/23/24 at 10:54 AM, during an interview, the [redacted]) stated abuse could be physical, mental, financial, denying care, forcing care, ignoring a patient, or an injury of unknown origin. She stated any allegation would be investigated and the facility would do a look back (review of staff working and caring for the resident) for the last 3 days and take statements from them to see if they witnessed anything. She stated the purpose of an investigation was to rule out abuse and to see if there is a trend. On 08/23/24 at11:47 AM, during an interview with the [redacted], the [redacted] stated that if there is an [redacted] an investigation would be done to find out if there was a root cause. She stated statements would be done to see if somebody saw something. The [redacted] stated it was a reportable event if they were unable to rule out abuse and it would be reported to the NJDOH) within 24 hours. The [redacted] reviewed the facility provided above-mentioned investigation in the presence of the surveyor and confirmed that it was the complete investigation. She then stated	F 609		

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F 609	Continued From page 5 the resident's [NJ Exec Order 26.4b1] were the cause of the [NJ Exec Order] On 08/23/24 at 12:55 PM, during an interview with the [U.S. FOIA (b)(6)], the [U.S. FOIA (b)(6)] stated he was the [NJ Exec Order 2] coordinator. He stated an [NJ Exec Order 26.4b1] would be reported to the NJDOH within 2 hours. He then stated they would "err on the side of caution and report it (to the NJDOH)." At that time, in the presence of the surveyor, the [U.S. FOIA (b)(6)] reviewed the above-mentioned incident investigation. After reading the investigation, the surveyor asked the [U.S. FOIA (b)(6)] what the cause of the injury was? The [U.S. FOIA (b)(6)] stated he would have "to look into it further." The surveyor asked if the completed investigation ruled out abuse, the [U.S. FOIA (b)(6)] stated, "I want to get back to you." The [U.S. FOIA (b)(6)] confirmed that the above-mentioned incident was not reported to the NJDOH. On 08/26/24 at 10:26 AM, the surveyor interviewed the [U.S. FOIA (b)(6)]. The surveyor asked the cause of the [NJ Exec Order] The [U.S. FOIA (b)] stated, "The resident has the behavior of [NJ Exec Order 26.4b1]." She then confirmed the staff statements did not reveal the staff witnessed the injury. The [U.S. FOIA (b)(6)] stated, "the preliminary did not show a cause." The [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)] both acknowledged that the incident should have been reported to the NJDOH but it was not. A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" dated 9/2023, revealed: "Policy Statement: "All reports of resident abuse (including injuries of unknown	F 609		

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F 609	Continued From page 6 origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Finding of all investigations are documented and reported...Reporting Allegations to the Administrator and Authorities 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to the state law. 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies; a. The state licensing/certification agency responsible for surveying/licensing the facility; b. The local/state ombudsman...3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse or result in serious bodily injury; or b. within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. 4. Verbal/written notices to agencies are submitted via carrier, fax, e-mail, or by telephone..." NJAC 8:39-9.4 (f)	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		9/16/24

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F 684	Continued From page 7 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of other facility documentation, it was determined that the facility failed to ensure [redacted] were consistently applied to prevent [redacted] This deficient practice was identified for Resident #89, 1 of 2 residents reviewed for [redacted] and [redacted]. This deficient practice was evidenced by the following: On 08/19/24 at 12:14 PM, during initial tour, the surveyor observed Resident #89 sitting in a reclining chair in the main activity area. The resident was NJ Exec Order 26.4b1 with their [redacted] NJ Exec Order 26.4b1. On 08/19/24 at 12:31 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #89 which revealed the following: A review of the Admission Record revealed the resident was admitted to the facility with diagnoses including but not limited to: [redacted] U.S. FOIA (b)(6) [redacted]. A review of the annual Minimum Data Set, an assessment tool dated [redacted] revealed the resident was unable to be interviewed for Brief Interview for Mental Status (BIMS) due to the "resident is NJ Exec Order 26.4b1 [redacted] A review of the Care Plan (CP) revealed a "Focus: [name redacted] has NJ Exec Order 26.4b1 [redacted], Date initiated:	F 684	1HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident # 89 was assessed, NJ Exec Order 26.4b1 findings noted. NJ Exec Order 26.4b1 were immediately applied. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: One to One education was given to the assigned U.S. FOIA (b)(6) [redacted] of resident #89, assigned U.S. FOIA (b)(6) [redacted] of resident #89, and U.S. FOIA (b)(6) [redacted] regarding constant application of NJ Exec Order 26.4b1 as per MD order. All nurses and nurse's aides educated by the DON/ designee on following MD orders to consistently apply NJ Exec Order 26.4b1 to prevent NJ Exec Order 26.4b1 and to ensure proper quality of care. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO	

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F 684	Continued From page 8 [redacted]. Goal: I will not experience any [redacted], Revision on: [redacted] Interventions: NJ Exec Order 26.4b1 [redacted]) [redacted] at all times, Date Initiated: [redacted] A review of the "Order Summary Report" revealed a physician's order (PO) for U.S. FOIA (b)(6) [redacted] every shift, start date [redacted]. On 08/20/24 at 10:34 AM, the surveyor observed the resident sitting in a reclining chair in the main activity area. The resident was [redacted] On 08/21/24 at 12:51 PM, the surveyor observed the resident sitting in a reclining chair in the main activity area. There was a staff member sitting with the resident, feeding the resident lunch. The resident was NJ Exec Order 26.4b1 [redacted]. On 08/22/24 at 11:07 AM, the surveyor observed the resident sitting in a reclining chair in the sensory room. The resident was [redacted] There was a staff member sitting with the resident NJ Exec Order 26.4b1. A review of the [redacted] Treatment Administration Record (TAR) revealed the PO for NJ Exec Order 26.4b1 every shift was signed as being completed for "Day" (7am to 3 pm shift) [redacted], [redacted], [redacted], and [redacted]. The surveyor NJ Exec Order 26.4b1 [redacted] resident as mentioned above. On 08/22/24 at 11:35 AM, during an interview with Resident #89s assigned U.S. FOIA (b)(6) [redacted], the [redacted] stated the resident	F 684	ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Director of Nursing or designee will complete random audits on 5 residents with ordered for heel booties weekly x 4 weeks, then monthly x 2 months. Results of the audits will be reported to the Administrator at the quarterly QA meeting.	

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F 684	Continued From page 9	F 684		

required [redacted]. The [redacted] stated she puts [redacted] on the resident every time she put the resident in bed. She stated she took the resident's [redacted] off this morning before she assisted the resident out of bed. The [redacted] took the surveyor to the resident's room and showed the surveyor where the [redacted] were located.

On 08/22/24 at 11:45 AM, during an interview, the [redacted] stated the resident [redacted] at nighttime. At that time, the [redacted] reviewed the order in the EMR, in presence of the surveyor. She stated, [redacted] every shift, means when in bed." She stated the purpose of [redacted] was to prevent [redacted].

On 08/22/24 at 11:55 AM, the [redacted]) reviewed the order in the EMR, in the presence of the surveyor. The [redacted] stated the order meant "while in bed." The surveyor asked if the [redacted] should be placed while the resident was in a recliner. The [redacted] stated, "yes." The [redacted] reviewed the resident's CP at that time, which revealed an intervention of "[redacted]" He then stated it meant the resident should have had [redacted] on at all times.

On 08/22/24 at 12:08 PM, the [redacted] reviewed the PO for [redacted] in the presence of the surveyor. She stated the [redacted] should be worn every time while in bed or while in a recliner. She stated the purpose of the [redacted] was to [redacted]. The [redacted] stated the purpose of the CP was so "everyone knew the daily care of the residents."

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F 684	Continued From page 10 A review of the facility's undated policy," Pressure Injury Prevention Guidelines" revealed: "Policy: To prevent the formation of avoidable pressure injuries and promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all resident who are assessed at risk or who have a pressure injury present. Policy Explanation and Compliance Guidelines: ...3. Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them." NJAC 8:39-27.1(e)	F 684		

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, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 9 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) 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	S 560	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Administrator, DON and staffing coordinator will work together to transfer staff to day shift to fulfil the requirement and ensure compliance. There is also a recruitment advertisement for LPNS, CNAS and RNS. Management is conducting weekly analysis on CNA needs. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All	9/16/24

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

Electronically Signed | 09/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12023	A. BUILDING: _____ B. WING _____	C 08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

(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 1 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. The survey team requested staffing for the weeks from 08/04/2024 to 08/17/2024. The facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -08/04/24 had 16 CNAs for 166 residents on the day shift, required at least 21 CNAs. -08/05/24 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/06/24 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/07/24 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/08/24 had 18 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/09/24 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/10/24 had 19 CNAs for 165 residents on the day shift, required at least 21 CNAs. -08/11/24 had 20 CNAs for 165 residents on the day shift, required at least 21 CNAs.	S 560	residents have the potential to be affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator educated the staffing coordinator on the importance of ensuring sufficient staffing for each shift. The staffing coordinator will audit the staffing par daily and staff each unit accordingly. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Nursing / Assistant Director of Nursing along with staffing coordinator will conduct staffing/scheduling audits 2 times per week x 4 weeks then monthly x 2 months to discuss staffing needs according to par levels with census. All findings will be reported to the Administrator at the quarterly QA meeting.	

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 2 -08/12/24 had 18 CNAs for 165 residents on the day shift, required at least 21 CNAs. On 08/23/24 at 11:29 AM, during an interview with the surveyor, the Staffing Coordinator (SC) stated she was aware of the CNA staffing ratios. She stated that for the most part, the facility was meeting the staffing ratios, but weekend day shifts were "a little harder." The SC stated that staffing was discussed daily with the Director of Nursing (DON). On 08/23/24 at11:40 AM, during an interview with surveyor, the DON stated "CNA staffing were sometimes very difficult to meet but we try." A review of the facility's policy, "Staffing" updated 1/2023, revealed: Policy Statement: Our Facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment ...Policy Interpretation and Implementation: 1. Licensed nurse and certified nursing assistants are available 24 hours a day to provide direct resident care services as required by Federal and State regulations."	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315509	A. Building B. Wing	9/25/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 09/20/2024	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 09/16/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
8/27/2024	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
12023	A. Building B. Wing	9/25/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/16/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
8/27/2024	☐ 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
	315509	A. BUILDING **01** B. WING _____	**08/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	**1133 MARLBORO ROAD** **OLD BRIDGE, NJ 08857**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/26/2024 and 08/27/2024, and Roosevelt Care 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. The facility is a four-story building that was built in 2011. It is composed of Type II protected construction. The facility is divided into 15-smoke zones. The generator does approximately 80% of the building as per the Director of Plant Operations.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		9/16/24

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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 222	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire	K 222		

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K 222	Continued From page 2 detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/27/2024 in the presence of the[U.S. FOIA (b)(6)] [redacted], it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101:2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 09:02 AM in the presence of the [redacted] revealed one set of glass sliding doors located at the front entrance of the facility had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The[U.S. FOIA (b)] tested the doors by locking and pushed to open, but he could not open the door. In an interview at the time, the [redacted] confirmed the observation. The [NJ Exec Order 26.4b1] was notified of the deficient practice at Life Safety Code survey exit conference at 12:15 PM. N.J.A.C. 8:39-31.2(e).	K 222	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Director of Maintenance removed the deadbolt on the main glass sliding door. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator educated [US FOIA (b)(6)] [redacted] and maintenance staff on the importance of ensuring that there are no deadbolts on exit doors. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Maintenance/Designee will audit 2 facility exit doors weekly x 4 weeks, then monthly x 2 weeks. Results of the audits will be reported to the	

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K 222	Continued From page 3	K 222	Administrator at the quarterly QA meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/26/2024, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to maintain the automatic fire sprinkler system and failed to ensure the ceiling level was smoke resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 3:08 PM in the storage closet	K 353	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The gap in the ceiling between the sprinkler head and the pipe in storage closet #242 has been fixed. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All	9/16/24

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K 353	Continued From page 4 #242, revealed 1 of 1 sprinkler head had a gap around the pipe in the ceiling. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] was notified of the deficient practice at Life Safety Code survey exit conference on 08/27/2024. N.J.A.C. 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator educated US FOIA (b)(6) [redacted] and maintenance staff on the importance of ensuring that there are no gaps in the ceiling between sprinkler heads and pipes. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Maintenance/Designee will audit 4 sprinkler heads weekly x 4 weeks, then monthly x 2 weeks. Results of the audits will be reported to the Administrator at the quarterly QA meeting.	
K 919 SS=F	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 919		9/16/24

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K 919	Continued From page 5 Based on observation and interview on 08/26/2024 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure the emergency generator was equipped with a remote manual stop station in accordance with NFPA 110 Standard for Emergency and Standby Power Systems: 2010 Edition, Section 5.6.5.6. This deficient practice had the potential to affect all residents at the facility and was evidenced by the following: An observation on 08/26/2024 at 9:25 AM, revealed that emergency generator was not equipped with a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the generator housing enclosure that was not remote from the unit to shut down in a catastrophic failure. The generator unit was located outside within a padlocked wood fence enclosure. An interview at the time of observation, the U.S. FOIA (b) [redacted] confirmed the generator was not equipped with a manual stop station that was remote from the unit. The facility's U.S. FOIA (b)(6) was informed of the deficient practice on 8/27/2024 during the Life Safety Code exit conference. N.J.A.C 8:39-31.2(e) NFPA 99, 110	K 919	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The generator Remote Manual Emergency Stop Switch was removed from within the padlocked wood fence enclosure and relocated to the remote area outside of the padlocked wood fence enclosure. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator educated US FOIA (b)(6) [redacted] and maintenance staff on the importance of ensuring that the facility generator Remote Manual Emergency Stop Switch is to be in a remote area and located outside the padlocked wood fence enclosure. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Maintenance/Designee	

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K 919	Continued From page 6	K 919	will audit the placement of the Generator Remote Manual Emergency Stop Switch weekly x 4 weeks and Monthly x 2 weeks. Results of the audits will be reported to the Administrator at the quarterly QA meeting.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3,	K 921		9/16/24

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ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

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K 921	Continued From page 7 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation review, on 08/26/2024 and 08/27/2024, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to provide the electrical policy for all patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and detailed log of all required tests, test results, safety labeled and repairs in accordance with NFPA 99: 2012 Edition, Section 10.3, 10.5.2.1,10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 08/26/2024 between 9:45 AM and 3:30 PM in resident rooms, revealed the following: 1. Room #U.S. FOIA (b)(6) had electric beds without inspection stickers. 2. Room [redacted] had a radio with no inspection sticker. 3. Room #[redacted] had an electric recliner chair and an electric shaving machine without an inspection stickers. 4. Room #NJ Exec Order 26.4b1 had electric standing fans without inspection stickers. In an interview at the time, the [redacted] confirmed the above observations. Documentation review on 08/27/2024 at 10:22 AM in the presence of the U.S. FOIA (b)(6) [redacted] revealed the facility did not provide policy and procedures for testing of the	K 921	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Room #[redacted] electrical beds were inspected, tested and logged in the maintenance book. Room [redacted] radio was inspected, tested and logged in the maintenance book. Room [redacted] electric recliner chair and electric shaving machine were inspected, tested and logged in the maintenance book. Room U.S. FOIA (b)(6) electric standing fans were inspected, tested and logged in the maintenance book. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator educated US FOIA (b)(6) [redacted] and maintenance staff on the importance of ensuring that all patient care related electrical equipment (PCREE) are to be inspected, tested and logged in the maintenance book. All PCREE in the facility have been inspected, tested and logged in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315509	A. BUILDING **01** B. WING _____	**08/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	**1133 MARLBORO ROAD** **OLD BRIDGE, NJ 08857**

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K 921	Continued From page 8 equipment, evidence of annual testing and maintenance program for PCREE. The administrator provided the surveyor with in-service sign-in sheets dated 08/26/2024, the first day of the survey after the observations. In an interview at the time, the [U.S. FOIA (b)] confirmed the above observation. The facility's [US FOIA (b)(6)] and the [U.S. FOIA (b)] were informed of the deficient practice during the Life Safety Code exit conference at 12:45 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 921	maintenance book. Director of maintenance has instituted that upon admission and as new pcree are brought into the facility they need to be inspected, tested and logged in the maintenance book prior to going into resident's rooms. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Maintenance/Designee will audit 4 patient care related electrical equipment (PCREE) weekly x 4 weeks and Monthly x 2 weeks. Results of the audits will be reported to the Administrator at the quarterly QA meeting.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		9/16/24

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	315509	A. BUILDING 01 B. WING _____	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

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K 923	Continued From page 9 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 08/26/2024, in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to store cylinder of compressed oxygen in a manner that would protect the cylinder against tipping and rupture in accordance with NFPA 99 Health Care Facilities Code (2012 Edition) Section 11.6.2.3(11). This deficient practice had the potential to affect all residents on the 4th floor and was evidenced by the following: An observation at 12:50 PM in room [redacted] revealed one portable cylinder of compressed oxygen gas was freestanding and not secured from tipping and rupture.	K 923	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The portable cylinder of compressed oxygen in room [redacted] was secured to ensure no tipping or rupture. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315509	A. BUILDING 01 B. WING _____	08/27/2024

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K 923	Continued From page 10 During an interview at the time of the observation, the US FOIA (b) confirmed the oxygen cylinder was not secured. He stated the staff know the oxygen cylinders need to be secure. The US FOIA (b) provided documentation of the training to the surveyor. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/27/2024. NJAC 8:39-31.2(e) NFPA 99	K 923	CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Administrator educated US FOIA (b)(6) maintenance staff on the importance of ensuring that all portable cylinders of compressed oxygen are secured to ensure no tipping or rupture. All portable cylinders of compressed oxygen have been audited to ensure they are secure from tipping or rupture. Director of maintenance has ensured that there are sufficient securing devices for all portable cylinders of compressed oxygen. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Director of Maintenance/Designee will audit 4 portable cylinders of compressed oxygen to ensure they are secured from tipping and rupture weekly x 4 weeks and Monthly x 2 weeks. Results of the audits will be reported to the Administrator at the quarterly QA meeting.	

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
315509 Y1	A. Building 01 - ROOSEVELT @ OLD BRIDGE B. Wing Y2	9/25/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER AT OLD BRIDGE	1133 MARLBORO ROAD OLD BRIDGE, NJ 08857

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 K0222	09/16/2024	LSC K0353	09/16/2024	LSC K0919	09/16/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0921	09/16/2024	LSC K0923	09/16/2024	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	

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	
8/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO