

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

PRINTED: 11/04/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315509</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/30/2022</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROOSEVELT CARE CENTER AT OLD BRIDGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1133 MARLBORO ROAD OLD BRIDGE, NJ 08857</b>		
(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	<p>INITIAL COMMENTS</p> <p>INFECTION CONTROL SURVEY</p> <p>CENSUS: 162</p> <p>SAMPLE SIZE: 7</p> <p>COVID + IN-HOUSE: 21</p> <p>A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/07/2022

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>12023</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>09/30/2022</b>
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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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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, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following:  Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	1. 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.	10/17/22

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NAME OF PROVIDER OR SUPPLIER  <b>ROOSEVELT CARE CENTER AT OLD BRIDGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1133 MARLBORO ROAD OLD BRIDGE, NJ 08857</b>		
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S 560	<p>Continued From page 1</p> <p>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.</p> <p>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and</p> <p>(3) 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 certified nurse aide and perform certified nurse aide duties</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides (CNA), for a shift, the number of required direct care staff members shall be rounded to the next higher whole</p>	S 560	<p>2. 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 the deficient practice. The supervisor and staffing coordinator will audit the staffing par for each unit every shift.</p> <p>3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The staffing coordinator will audit the staffing par daily and staff each unit accordingly to the unit census.</p> <p>4. 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 Nursing /Assistant Director of Nursing along with staffing coordinator will conduct staffing/scheduling audits 2 times per week x 4 weeks to discuss staffing needs according to par levels with census. All findings will be reported during QAPI monthly.</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>ROOSEVELT CARE CENTER AT OLD BRIDGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1133 MARLBORO ROAD OLD BRIDGE, NJ 08857</b>		
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S 560	<p>Continued From page 2</p> <p>number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 7/3/22 and 7/10/22 revealed the following:</p> <p>The facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows:</p> <p>The facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> <li>-09/11/22 had 16.50 CNAs for 160 residents on the day shift, required 20 CNAs.</li> <li>-09/12/22 had 16 CNAs for 160 residents on the day shift, required 20 CNAs.</li> <li>-09/13/22 had 17 CNAs for 160 residents on the day shift, required 20 CNAs.</li> <li>-09/16/22 had 19.50 CNAs for 162 residents on the day shift, required 20 CNAs.</li> <li>-09/17/22 had 19 CNAs for 162 residents on the day shift, required 20 CNAs.</li> <li>-09/18/22 had 15 CNAs for 163 residents on the day shift, required 20 CNAs.</li> <li>-09/21/22 had 19 CNAs for 163 residents</li> </ul>	S 560		

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S 560	Continued From page 3  on the day shift, required 20 CNAs. -09/22/22 had 17 CNAs for 166 residents on the day shift, required 21 CNAs. -09/24/22 had 18 CNAs for 165 residents on the day shift, required 21 CNAs.  On 9/30/22 at 1:30 PM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria.	S 560		

# STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 12023	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/1/2022
NAME OF FACILITY ROOSEVELT CARE CENTER AT OLD BRIDGE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/17/2022	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	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR		DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/30/2022		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			