STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

(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 COMPLAINT: NJ 00164733 CENSUS: 160 SAMPLE SIZE: 3 THE FACILITY IS NOT IN COMPLIANCE WITH THE REQUIREMEMNTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	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 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	F 609		8/7/23

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

Electronically Signed | 07/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

(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 609	Continued From page 1 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: C#: NJ00164733 Based on interviews and a review of the medical records (MRs) and other facility documentation on 6/9/23, it was determined that the facility staff failed to report an NJ Exec Order 26.4b1 origin to the New Jersey Department of Health (NJDOH) as required and according to the facility's policy "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" for 2 of 3 sampled residents (Resident #1) reviewed for incident and accident investigation and reporting. This deficient practice was evidenced by the following: 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on NJ Exec Order 26. with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 . A Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 2, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of NJ E which indicated NJ Exec Order 26.4b1, and the resident required assistance with activities of daily living (ADLs). During the tour on 6/9/23 at 9:13 am, in the presence of the Unit Manager/Registered Nurse (UM/RN) and Certified Nursing Assistant (CNA #1), the surveyors observed Resident #1 had	F 609	1. The residents found to be affected (Residents # 1 and # 2) will be reported to the NJ Department of Health (DOH) and the NJ Office of the Ombudsman for the Institutionalized Elderly (OOIE). 2. All residents have injuries of unknown source have the potential to be affected; therefore, this plan of correction applies to all residents, current and future. 3. The Administrator and Director of Nursing (DON) were re-in serviced / educated on Federal Regulation F609, and on the NJ Reportable Event Grid by the Regional Clinical Consultant on 7-24-23. In addition, after-hours and weekend supervisors will be re in serviced /educated by the ADON, Rick Manager or designee on the reporting requirements for continued real-time notification of reportable events to the Administrator and Director of Nursing. 4. The incident/accident reports, and daily 24-hour report, will be audited by the Director of Nursing (DON), or her designee, and the Administrator to ensure incidents requiring reporting are reported timely according to F 609 and the NJ Mandatory Reporting Guidelines. This audit will be performed weekly for four (4)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

(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 609	Continued From page 2 NJ Exec Order 26.4b1 . UM/RN stated that the NJ Exec Order 26.4b1 was a "NJ Exec Orde." According to UM/RN, Resident #1 acquired the NJ Exec Order 26.4b1 from leaning against the wall. The investigation report (IR), dated NJ Exec Order 26.4b1 at 7:00 am, indicated that during care, Resident #1 had a NJ Exec Order 26.4b1 . The IR further indicated that Resident #1 was NJ Exec Order 26.4b1 and that there was no witness found. The IR revealed that on NJ Exec Order 26 the Director of Nursing (DON) documented "Upon investigation and statements obtained from staff, a nurse stated that she observed the resident's r NJ Exec Order 26.4 and she repositioned resident in bed NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 Resident's bed moved away from the wall and placed at the center of the room. Maintained in a NJ Exec Order 26 and provided with NJ Exec Order 26.4b1 on both sides for safety precautions...Resident has NJ Exec Order 26.4b1 r/t NJ Exec Order 26.4b1 ...Resident has NJ Exec Order 26.4b1 r/t dx.[diagnosis] of NJ Exec Order 26.4b1 . Resident has NJ Exec Orde r/t NJ Exec Orde." Attached with the IR, the statement from the Licensed Practical Nurse (LPN #1), dated NJ Exec Order 26. LPN #1 documented "On NJ Exec Order 2 at 2:00 pm when doing rounds as I enter the room of [Resident #1] noticed the NJ Exec Order 26.4b1 then I repositioned her/him to [the] middle of [the] bed, NJ Exec Order 26.4b1 ."	F 609	weeks, then monthly for three (3) months. The DON will submit these audit reports to the Administrator and Quality Assurance Committee, which meets quarterly, for review, and will make recommendations on the need for continued audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

(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 609	Continued From page 3	F 609		

Attached with the IR, the statement from the CNA #1, dated [NJ Exec Order 26.4b1]. The CNA documented that at 6:30 am during her initial rounds she noticed a [NJ Exec Order 26.4b1] and reported it to the nurse.

Review of Resident #1's progress notes (PN), dated [NJ Exec Order 26.4b1] at 7:00 am, documented by a Registered Nurse (RN #1), indicated what was written on the IR. The PN further indicated that Resident #1's [NJ Exec Order 26.4b1]. Resident #1 did not [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1]. There was no indication in the PN that Resident #1 was observed and/or assessed for any injury from [NJ Exec Order 26.4b1] through [NJ Exec Order 26.4b1].

The "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status and care provided to the resident for [NJ Exec Order 26.4b1], documented by the CNAs who provided care to Resident #1, reflected that on [NJ Exec Order 26.4b1] from 3:00 pm to 11:00 pm through [NJ Exec Order 26.4b1] from 11:00 pm to 7:00 am shift, Resident #1's [NJ Exec Order 26.4b1].

The surveyor was unable to interview Resident #1 due to [NJ Exec Order 26.4b1].

2. According to the AR, Resident #2 was admitted to the facility on [NJ Exec Order 26.4b1] with diagnoses which included but were not limited to: [NJ Exec Order 26.4b1].

An MDS, dated [NJ Exec Order 26.4b1], revealed that Resident #2 had a BIMS score of [NJ Exec Order 26.4b1] which indicated [NJ Exec Order 26.4b1] and the resident needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

(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 609	Continued From page 4	F 609		

assistance with ADLs.

The PN, dated [redacted] at 11:03 am, indicated that around 8:00 am, during medication administration, Licensed Practical Nurse (LPN #2) noticed some [redacted] to Resident #2's [redacted]. The IR further indicated that at 9:00 am, LPN #2 noticed [redacted]

The IR, dated [redacted] at 11:03 am, indicated that at 8:00 am, during medication administration, LPN #2 noticed some [redacted] to Resident #2's [redacted]. At 9:00 am, Resident #2's [redacted], the resident's [redacted] According to the IR, Resident #2 had [redacted] and there was no witnessed. The DON documented on the IR that the Interdisciplinary Team (IDT) met on [redacted] to discuss the incident that occurred on [redacted]. The DON stated that the resident reported that [redacted] resident had [redacted] and none of the staff witnessed any [redacted] on or prior to [redacted]. The DON further stated on [redacted] at 6:00 am, CNA #2 observed Resident #2's face was laying on the bed's side rail.

Attached with the IR, the statement from CNA #2, dated [redacted], the CNA indicated that she provided morning care to the resident and did not notice any changes. The statement dated [redacted] did not indicate that the resident's face was leaning/laying on the side rails of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

(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 609	Continued From page 5	F 609		

During an interview with the surveyors on 6/9/23 at 4:10 pm, the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA), in the presence of Regional Clinical Nurse (RCN) and Director of Clinical Services (DOCS) explained that one of the criteria for an [NJ Exec Order 26.4b1] [redacted] which was included but not limited to a "[NJ Exec Order 26.4b1]" They both agreed that it is their responsible to report to the NJDOH if there was an NJ Exec Order 26.4b1 The DON explained that on [NJ Exec Order 26.4b1] at around 8:00 am, she was made aware that Resident #1 had a [NJ Exec Order 26.4b1]" on the NJ Exec Order 26.4b1 and immediately began an investigated. According to the DON, the incident was not reported to the NJDOH because during the investigation LPN #1 saw Resident #1 leaning against the wall on [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1] as she stated on her statement on [NJ Exec Order 26.4b1].

The facility was unable to provide documentation that the aforementioned incidents were reported to the NJDOH.

A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" dated 9/2022, included but was not limited to: "All reports of resident abuse (including injuries of unknown 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315039	A. BUILDING _____ B. WING _____	C 06/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	**118 PARSONAGE ROAD EDISON, NJ 08837**

(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 609	Continued From page 6 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		

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)
315039	A. Building B. Wing	8/14/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROOSEVELT CARE CENTER	118 PARSONAGE ROAD EDISON, NJ 08837

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 08/07/2023	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	
6/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO