

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

PRINTED: 05/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>315039                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>07/29/2022 |
|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>ROOSEVELT CARE CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>118 PARSONAGE ROAD<br>EDISON, NJ 08837 |  |  |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                           |
| F 000   | INITIAL COMMENTS<br><br>COMPLAINT # NJ 151228, 152246, 152424,<br>153710.<br><br>CENSUS: 169<br><br>SAMPLE SIZE: 7<br><br><br>THE FACILITY IS NOT IN SUBSTANTIAL<br>COMPLIANCE WITH THE REQUIREMENTS OF<br>42 CFR PART 483, SUBPART B, FOR LONG<br>TERM CARE FACILITIES BASED ON THIS<br>COMPLAINT VISIT.  | F 000   |  |  |
| F 609<br>SS=D   | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse,<br>neglect, exploitation, or mistreatment, the facility<br>must:<br><br>§483.12(c)(1) Ensure that all alleged violations<br>involving abuse, neglect, exploitation or<br>mistreatment, including injuries of unknown<br>source and misappropriation of resident property,<br>are reported immediately, but not later than 2<br>hours after the allegation is made, if the events<br>that cause the allegation involve abuse or result in<br>serious bodily injury, or not later than 24 hours if<br>the events that cause the allegation do not involve<br>abuse and do not result in serious bodily injury, to<br>the administrator of the facility and to other<br>officials (including to the State Survey Agency and<br>adult protective services where state law provides<br>for jurisdiction in long-term care facilities) in<br>accordance with State law through established | F 609   |  | 8/5/22   |

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

TITLE

(X6) DATE

Electronically Signed

08/05/2022

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.

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

PRINTED: 05/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION          |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>315039 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                | (X3) DATE SURVEY COMPLETED<br><br>C<br>07/29/2022   |
|---|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>ROOSEVELT CARE CENTER |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>118 PARSONAGE ROAD<br>EDISON, NJ 08837 |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   |  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  |
| F 609   | <p>Continued From page 1 procedures.</p> <p>§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:</p> <p>COMPLAINT # NJ 153710</p> <p>Based on interviews, Medical Record (MR) review, and review of other pertinent Facility documents on <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.1</a> and <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.2</a>, it was determined that the Facility failed to report that Resident #6 <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.3</a> [REDACTED] [REDACTED] to the New Jersey Department of Health (NJDOH) as required as well as follow their policy titled "Elopement/Missing Residents Policy and Procedure," for 1 of 7 residents (Resident #6) reviewed for incident and accidents. The facility was unaware of the Resident's <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.4</a> [REDACTED] This deficient practice was evidenced by the following:</p> <p>According to the Medical Record Resident #6 was admitted to the facility on <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.5</a>, with diagnoses which included but were not limited to: <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.6</a> [REDACTED]</p> <p>The Minimum Data Set (MDS), an assessment tool dated <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.7</a>, showed Resident #6 had a Brief Interview for Mental Status (BIMS) score of</p> |  | F 609   | <p>1. Resident #6 <a href="#">Exec Order 26, 4b1 NJAC 8:43E-2.8</a> [REDACTED]</p> <p>2. All residents could have been affected by this deficient practice.</p> <p>3. Administrator and Director of Nursing educated by Regional Administrator on the policy and procedure for reporting alleged violations to Department of Health.</p> <p>DON/designee to conduct weekly audit monitoring of safe scheduled medical transports for one month, then monthly for 2 months.</p> <p>4. Administrator to monitor and review audits at quarterly QA meeting for 3 months.</p> |

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

PRINTED: 05/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>315039                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>07/29/2022 |
|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>ROOSEVELT CARE CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>118 PARSONAGE ROAD<br>EDISON, NJ 08837 |  |  |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                           |
| F 609   | <p>Continued From page 2</p> <p><span style="color: red;">[REDACTED]</span>, which indicated <span style="color: red;">[REDACTED]</span></p> <p>The MDS also indicated Resident #6<br/><b>Exec Order 26, 4b1 NJAC 8:43E-2.1</b></p> <p><span style="color: red;">[REDACTED]</span></p> <p>A review of the Progress Notes for Resident #6 dated <span style="color: red;">[REDACTED]</span>, documented by the Registered Nurse (RN) revealed the following: At <span style="color: red;">[REDACTED]</span> the Resident went out for an appointment to the Doctor's office, picked up by the transport company. The Resident <span style="color: red;">[REDACTED]</span> after the appointment. The Nurse Manager, Director of Nursing (DON), and family member were notified. At <span style="color: red;">[REDACTED]</span> the Resident returned to the facility via transport. A physical assessment was completed by the nurse and no <span style="color: red;">[REDACTED]</span> was noted and <span style="color: red;">[REDACTED]</span> was intact.</p> <p>A review of the facility statement dated <span style="color: red;">[REDACTED]</span>, the Unit Secretary (US) documented, she called the transport company on <span style="color: red;">[REDACTED]</span> (no time listed), to inform them that Resident #6 was ready for pickup at the doctor's office. The transport company called back later and informed the US that Resident #6 <span style="color: red;">[REDACTED]</span> the doctor's office. The US called the doctor's office who confirmed that Resident #6 <span style="color: red;">[REDACTED]</span></p> <p>A review of the facility statement dated <span style="color: red;">[REDACTED]</span>, the Unit Manager (UM) documented, she was informed by the US that the transport company called and said, when they arrived at the doctor's office Resident #6 <span style="color: red;">[REDACTED]</span> The UM and the US went to the doctor's office <span style="color: red;">[REDACTED]</span><br/><span style="color: red;">[REDACTED]</span></p> <p>A review of the facility statement dated <span style="color: red;">[REDACTED]</span> documented by the Administrator, Resident #6 had a doctor appointment on <span style="color: red;">[REDACTED]</span>, and</p> | F 609   |  |  |

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

PRINTED: 05/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>315039                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>07/29/2022 |
|---|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>ROOSEVELT CARE CENTER |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>118 PARSONAGE ROAD<br>EDISON, NJ 08837 |  |  |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                           |
| F 609   | <p>Continued From page 3</p> <p>when the transport arrived at the doctor's office the Resident [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> The Police called the facility at approximately [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> on [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> to report that Resident #6 [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> Upon return to the facility Resident #6 was alert and oriented and did not express [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> [REDACTED] but the Resident was not aware that the staff should have been notified of the plan <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> The Resident acknowledged that in the future the staff should be notified.</p> <p>Resident #6's medical record including physician orders did not indicate that Resident #6 [REDACTED] <small>EXEC ORO</small> [REDACTED]</p> <p>During an interview on 7/29/2022 at 10:29 a.m., the Unit Manager stated, she and the US searched the whole building, someone (did not specify name) from the facility called the Police. After searching the building they checked the neighborhood, restaurants, the bank, and other buildings close by but they were unable to locate Resident #6. They went back to the doctor's office and the Police were there. The Police said the Resident [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small>.</p> <p>During an interview on 7/29/2022 at 10:56 a.m., the Director of Nursing acknowledged, Resident #6 <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> [REDACTED] until the Police <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small>.</p> <p>During an interview on 7/29/2022 at 11:33 a.m., the Administrator acknowledged, that Resident #6 did not have authorization or a doctor's order to [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> on [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small> and it was a safety concern that Resident #6 left the doctor's office [REDACTED] <small>Exec Order 26, 4b1 NJAC 8:43E-2.1</small></p> | F 609   |  |  |

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

PRINTED: 05/10/2024  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>315039                 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br>C<br>07/29/2022 |
|---|--|---|--|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>ROOSEVELT CARE CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>118 PARSONAGE ROAD<br>EDISON, NJ 08837 |  |  |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE                           |
| F 609   | <p>Continued From page 4</p> <p>According to the Facility Policy titled "Elopement/Missing Residents Policy and Procedure," under "Policy" revealed the following: It is always the policy of the facility to protect residents by identifying and preventing the possibility of elopement and locating residents who are reported missing. Under "Return" #8. A written report statement detailing the incident will be provided to the Department of Health.</p> <p>N.J.A.C. 8:39-5.1(a)</p> | F 609   |  |  |

## POST-CERTIFICATION REVISIT REPORT

|   |   |   |
|---|---|---|
| PROVIDER / SUPPLIER / CLIA /<br>IDENTIFICATION NUMBER<br>315039 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing<br>Y1 | DATE OF REVISIT<br>Y2<br>8/24/2022<br>Y3  |
| NAME OF FACILITY<br>ROOSEVELT CARE CENTER                       |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>118 PARSONAGE ROAD<br>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<br>Y4             | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 |
|------------------------|------------|------------|------------|------------|------------|
| ID Prefix F0609        | Correction | ID Prefix  | Correction | ID Prefix  | Correction |
| Reg. # 483.12(c)(1)(4) | Completed  | Reg. #     | Completed  | Reg. #     | Completed  |
| LSC                    | 08/05/2022 | 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<br>STATE AGENCY                  | <input type="checkbox"/> | REVIEWED BY<br>(INITIALS)  | DATE | SIGNATURE OF SURVEYOR |  |
| REVIEWED BY<br>CMS RO                        | <input type="checkbox"/> | REVIEWED BY<br>(INITIALS)  | DATE | TITLE                 |  |
| FOLLOWUP TO SURVEY COMPLETED ON<br>7/29/2022 |                          | <input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF<br>UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |      |                       |  |