

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
NAME OF PROVIDER OR SUPPLIER Roosevelt Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Parsonage Road Edison, NJ 08837	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>45208</p> <p>Based on observation, interview and review of other facility documentation, it was determined that the facility failed to protect resident's privacy and independence in a dignified manner. This deficient practice was identified for one (1) of 30 residents reviewed for dignity and well-being (Resident #53).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 4/22/24 at 10:58 AM, the surveyor observed on the front of Resident #53's room door (hallway side) signage that read, Attention, room [# redacted] [name redacted], needs to be fed by the nurse only! Please read and take note: Nurse Feeder, room [# redacted], [name redacted], dated 3/15/24. Another sign on the same door revealed, Stop and Read: Do not give [name redacted] the remote control for bed. Thank you.</p> <p>On 4/22/24 and 4/30/24 at 11:00 AM, the surveyor observed Resident #53 in bed, appeared to be asleep with the television on, the bed was equipped with an air mattress. The head of the bed (HOB) was elevated, the call bell was in reach and on the bed. The remote control for the bed was attached behind the HOB on the headboard. It was not in the resident's reach.</p> <p>The surveyor reviewed Resident #53's medical record.</p> <p>The admission record (an admission summary) revealed medical diagnosis which included but were not limited to: cerebral vascular infarction (CVA, a stroke happens when there is a loss of blood flow to part of the brain), dysphagia (difficulty or discomfort in swallowing, as a symptom of disease), bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), and morbid obesity (more than 100 lbs. over your ideal body weight), chronic obstructive pulmonary disease (COPD) (inflammatory lung disease that causes obstructed airflow from the lungs).</p> <p>The comprehensive Minimum Data Set, an assessment tool used to facilitate the management of care, dated 01/22/24, revealed the resident had a Brief Interview for Mental Status (BIMS) (a mandatory tool used to screen and identify the cognitive condition of residents) revealed a score of 9 out of 15, suggesting moderate cognitive impairment.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The resident's ongoing Care Plan indicated a focus for nutrition, a goal for prevention of aspiration or choking and an intervention to monitor intake of solid food and liquids.</p> <p>On 4/30/24 at 9:08 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated, the nurse or certified nursing assistant is instructed to feed and monitor the resident's intake. I do not know who put the signs on the door. The sign for the bed controller is because the resident lays their HOB flat and is detrimental for the residents breathing.</p> <p>On 4/30/24 at 9:16 AM, the surveyor interviewed the Director of Nursing (DON) who stated I round, twice a week, my rounds are looking for environmental issues, rooms issues, residents' issues, and I greet all new admissions. I trust my unit managers (UM) because they will let me know if there are any issues with staff or residents, and the environment. Then I will let the specific department know of the problem or give education and in services if needed. She further stated, I did not see it. I would have taken it down immediately; it is not a good sign you should not be having a sign and the resident should have their remote. I will investigate this and let you know.</p> <p>On 4/30/24 at 10:16 AM, the surveyor interviewed the [NAME] President of Clinical (VPoC) and the Licensed Nursing Home Administrator (LNHA) who both stated, the sign on the door is against HIPAA (Health Insurance Portability and Accountability Act, federal law that requires the creation of national standards to protect sensitive patient health information from being disclosed). It should not be hung on the door like that.</p> <p>A review of the Residents Rights policy, adopted 11/2018 and updated 10/2021, revealed policy interpretation and implementation #1 a.) a dignified existence, b.) be treated with respect, kindness, and dignity. #3) The unauthorized release, access, or disclosure of resident information is prohibited. All release, access, or disclosure of resident information must be in accordance with current laws governing privacy of information issues. All inquiries concerning the release of resident information should be directed to the HIPAA compliance officer.</p> <p>A review of the Resident Room Posting policy, dated 01/01/22, revealed:</p> <p>Policy: it is the policy of this facility to support a residents right to personal privacy and confidentiality in all aspects of care and services, to include personal and medical records.</p> <p>Definition: confidentiality is defined as safeguarding the content of information including video, audio, or other computer stored information from unauthorized disclosure without the consent of the resident and/or the individuals surrogate or representative.</p> <p>Policy explanation and compliance guidelines:</p> <p>1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups .</p> <p>5) Documentation will be made in the resident's medical record should the facility decide that for the residents well being a visual cue as a reminder is necessary.</p> <p>7) Any use of a resident room posting(s) will be documented in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/02/24 at 01:00 PM, the survey team met with the DON, LNHA and VPoC. The administration team acknowledged the regulatory issues with the signage and had no further information to provide.</p> <p>NJAC 8:39-17.2(e)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37791</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to address a Do Not Resuscitate (DNR) (It's a medical order that instructs health care providers not to perform cardiopulmonary resuscitation (CPR) if a patient's breathing stops or if the patient's heart stops beating) and Do Not Intubate (DNI) (a medical document that indicates a patient does not want to be intubated or receive CPR in event of cardiopulmonary arrest) code status order signed by the resident's family and Physician with no follow-up change of the physician's order (PO) or update of the comprehensive care plan to indicate a code status change. This deficient practice was identified for 1 of 33 residents, (Resident #55) reviewed for advanced directives.</p> <p>This deficient practice was evidenced by the following:</p> <p>On [DATE] at 10:15 AM, the resident was observed in the day room seated in a wheelchair looking through a newspaper. The resident was receiving 2 Liters per meter (LPM) of oxygen via a nasal cannula from a portable oxygen concentrator.</p> <p>The surveyor reviewed the medical record for Resident #55.</p> <p>The Admission Record reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), chronic obstructive pulmonary disease (a lung disease that block airflow and make it difficult to breathe), major depressive disorder (a condition with a persistently low and depressed mood) and hypertension (a condition in which the force of blood against the artery walls is to high).</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [DATE], reflected that the resident had a brief interview for mental status (BIMS) score of 4 out of 15, indicating that the resident was severely impaired.</p> <p>A review of the [DATE] Order Summary Report (OSR) revealed a PO dated [DATE] for a Full Code Status (if a patient's heart stops beating or stop breathing, medical professionals will provide all possible resuscitation procedures to keep them alive).</p> <p>A review of Resident #55's Care Plan (CP) revealed a Full Code Status with an initiation date of [DATE].</p> <p>A review of the New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) revealed that the resident's family and the physician signed the signature section of the POLST on [DATE] for the following areas:</p> <p>- Goals of Care: Comfort Care</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- Medical interventions: Limited treatment (use appropriate medical treatment such as antibiotics and IV fluids as indicated. May use non-invasive positive airway pressure.), Transfer to hospital only if comfort needs can't be met at the current location, and additional orders: DNR and DNI.</p> <p>- Artificially administered fluids and nutrition- no artificial nutrition.</p> <p>- Cardiopulmonary Resuscitation (CPR): Do not attempt resuscitation (DNR) allow natural death.</p> <p>On [DATE] 10:31 AM, the surveyor in the presence of the Registered Nurse/ Unit Manager (RN/UM) reviewed the resident's medical records. The RN/UM acknowledge that the resident was a full code according to the physician's order. The RN/UM also acknowledged that the resident's care plan indicated that the resident was a Full Code. The surveyor requested the RN/UM to check the resident's POLST which was under the miscellaneous tab of the computerized medical record. The RN/UM opened the POLST form that had the family and physician's signature date of [DATE]. At that time, she acknowledged that the resident had a DNR and DNI code status. She told the surveyor that the procedure of a change of a POLST was for the physician to notify nursing regarding a change of order and, at that time, the physician's order and care plan would be updated with the new code status. The RN/UM further stated that the POLST was important because it was a matter of life and death.</p> <p>On [DATE] at 11:05 AM, the surveyor interviewed the facility Social Worker (SW) who confirmed that she met with the resident's family (wife and son) on [DATE] and discussed the resident's current POLST. The SW stated that the RN/UM manager was present at the meeting. The new POLST with a status change of DNR and DNI was signed by the family in front of the SW and the RN/UM. The SW further stated that the physician who was at the facility, came to the meeting and signed the POLST. Once both parties sign the POLST the RN/UM was supposed to initiate a change of a Code status and update the care plan. The SW stated once the POLST signed by both parties (family and physician) it (the code status) should have been initiated immediately.</p> <p>On [DATE] at 1:00 PM, the surveyor presented the above concern to the facility administration team which included the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the [NAME] President of Clinical services (VPC).</p> <p>There was no additional information provided.</p> <p>A review of the facility's policy for Advance Directives revised on ,d+[DATE], and was provided by the VPC revealed the following:</p> <p>18. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument (MDS).</p> <p>19. The care plan team will be informed of such changes and/or revocations so that appropriate changes can be made in the resident assessment (MDS) and care plan.</p> <p>20. The Director of Nursing services or designee will notify the attending physician of advance directives so that appropriate orders can be documented in the resident's medical record and plan of care. The attending physician will not be required to write orders for which he or she has an ethical or conscientious objection.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41858</p> <p>Complaint # 171606</p> <p>REPEAT DEFICIENCY</p> <p>Based on interviews, review of the medical records (MRs) and other facility documentation, it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health (NJDOH) as required and according to the facility's policy for 2 of 3 residents (Resident #210 and # 211) reviewed for injury of unknown origin.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. According to the admission record (AR), Resident #210 was admitted to the facility with diagnosis which included but were not limited to: Chronic kidney disease Stage 4 (a gradual loss of kidney function) and chronic embolism and thrombosis of unspecified deep veins of left lower extremity (a blood clot in a deep vein that has lasted for at least a month).</p> <p>A review of the quarterly Minimum data set (MDS) an assessment tool, dated 12/20/2023, revealed the resident had a brief interview of mental status (BIMS) of 9 out of 15 which indicated that the resident was moderately cognitively impaired. Further review revealed the resident had upper and lower extremity impairment on both sides.</p> <p>A review of the Care Plan (CP) revealed a Focus of an ADL self-care performance deficit/limited mobility r/t decrease muscle strength Date Initiated: 12/15/2023.</p> <p>A review of progress notes dated 2/16/2024 at 07:56 AM revealed a General Note, Note Text: The writer was notified by Nurse that resident right lower leg is swollen and complaining of pain. Immediately went to resident room. Upon assessment hematoma noted at right lower leg measurement 9.0 x7.0. MD and family notified. STAT X-Ray ordered. Tramadol given for pain as well as cold compress applied. DON made aware.</p> <p>On 04/24/24 at 11:06 AM, the surveyor interviewed the Social Worker Director (SWD) in the presence of the survey team. The SWD stated that an allegation of abuse or injury of unknown origin would be reported to the Interdisciplinary Team and or the Director of Nursing immediately. She stated we have a concern form and we start an investigation. The SWD stated that alert and oriented residents were interviewed and asked, have you been treated in abusive manner. She further stated if there was an allegation of abuse, the staff member was removed from the schedule immediately.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 04/24/24 at 1:25 PM, the LNHA provided the surveyor with an investigation for an injury of unknow origin for Resident # 210. A review of the Investigation revealed an Incident Report dated 2/16/24 at 03:45, Incident Description: The writer was notified by the aide at 3:45 am that resident right lower leg is swollen and complaining of pain. Immediate Action Taken: Description: Call made to supervisor and came down to do assessment with the writer. Upon assessment hematoma noted at the right lower leg measurement 0.9 X 7.0. PRN Tramadol (a pain medication) 50 mg(milligrams) given for pain, and it was effective. Resident positioned comfortably in bed after care given with O2 (oxygen) running via N/C (nasal cannula). Cold compress applied to the affected site and was well tolerated. Message left for MD's answering service to call back and the daughter too made aware.Notes: 2/16/24 On investigation, at around 11 pm of February, the 3 to 11 Nurse said he did his rounds and observed that the resident's legs were hanging from the side of the bed. He assisted the resident's legs back to bed and the resident became agitated and verbally abusive and confused. The nurse called the resident's daughter, no further complaints or behavioral issues documented. This nurse obtained an order for UA/CS (urinalysis/culture and sensitivity) for confusion. At the change of shift, the 3 to 11 shift nurse endorsed to 11-7 nurse about the resident's behavior, the 11-7 nurse did her rounds and noted that the resident was in his/her bed, not in any from of distress. At 0345 was when the CNA informed her about the resident having swelling on the right calf.</p> <p>On 04/26/24 at 10:24 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the above incident. The LNHA stated the process for injury of unknow origin was to immediately investigate and start taking statements from all of staff that took care of the resident for the past 48 hours. He stated, they do a reenactment, so I am clear what happened. He further stated, if the resident was alert and oriented, we interview them, we notify the family and the physician. The LNHA stated that the Social Worker (SW) interviews the residents. He stated, if it involved a staff member, we remove them immediately and they are suspended while the investigation was ongoing. He further stated, We report it to the Department of Health (DOH) and the Ombudsman. If it was a definite allegation of abuse, we report it within 2 hours, if not, we report within 24 hours.</p> <p>At that time, the LNHA stated that we did not report it initially because we knew the cause (of the injury). He then stated, we reconvened on 2/21/24 when we heard from the hospital that the resident's condition had escalated at that point, so we called it (the incident) to the DOH on 2/21/24 at 12:15 PM. The LNHA stated, On 2/22/24, after receiving an email from the resident's daughter that the resident stated that a nurse caused the injury, we (the facility) called it in again at 5:20 PM.</p> <p>A review of the above-mentioned email dated 2/22/2024 at 03:18 PM revealed: On Friday, February 15, 2024, {name redacted} (Resident # 210) was seriously injured .Naming {name redated} (night nurse 3:00PM-11:00pm) as the person who inflicted this injury. A review of the facility investigation revealed that the facility immediately removed the nurse in question from the schedule and conducted a complete investigation.</p> <p>2. According to the AR, Resident #211 was admitted to the facility with diagnosis which included but were not limited to: End stage renal disease (when the kidneys no longer filter wastes and fluids from your blood) and Dependency on Renal Dialysis.</p> <p>A review of the admission MDS, dated [DATE], revealed the resident had a BIMS of 13 out of 15 which indicated that the resident was cognitively intact. Further review, revealed the resident was independent with activities of daily living.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Care Plan (CP) revealed a Focus: [name redacted] is on anticoagulant (medications that prevent or break down blood clots) therapy which put him/her at risk for bleeding/bruising, date initiated 4/10/24.</p> <p>A review of the progress note dated 4/17/2024 at 12:11 pm revealed: Note text: Around 9:45am it was brought to my attention by MD resident has a bruise on the right should. Upon assessment complain of pain but refused to be medicated or for area to be measured. Xray ordered called in done by [name redacted] right elbow, shoulder, chest. Family son is aware of xray order .</p> <p>On 04/24/24 at 1:25 PM, the LNHA provided the surveyor with an investigation for an injury of unknow origin for Resident # 211. A review of the incident report dated 4/17/2024 at 12:00 revealed: Incident Description: I writer was called to the room by Dr. [name redacted] on bruise noted on resident right shoulder. Unable to measure bruise as resident refused. Resident Description: Statement happen during bed change/transfer on 4/15/24 .Notes 4/17/2024 Interviewed the dialysis staff. Interviewed EMS transporters. Will do body assessment upon return from dialysis .</p> <p>On 04/26/24 at 10:52 AM, the surveyor interviewed the LNHA and the DON regarding the above incident. The DON stated, after our investigation, we determined that the bruising was from the blood pressure cuff being put on over the resident's sleeve during dialysis. She also stated that the resident was on an anticoagulant. The LNHA confirmed the incident was called in to the DOH on 4/18/24 at 8:30 PM. He then stated, It was over the time limit, it should have been called in before 12:00 that day(4/18/24).</p> <p>On 5/1/24 at 1:00 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA), the Administrator in training (AIT), the [NAME] President of Clinical (VPC), and the DON, the surveyor presented the above concerns for Resident #210 and #211.</p> <p>On 5/2/24 at 11:07 AM, during a meeting with the survey team, the LNHA, the AIT, and the DON, in regard to reporting injuries of unknown origin to the DOH, the VCP acknowledged they (incident for Resident #210 and #211) were reported late. She stated they need to make sure anytime there was an injury of unknown, if the cause was unknown, it must be reported immediately. The VCP stated the purpose was because it was a requirement and we need to make sure we follow it to rule out abuse, start investigation immediately to make sure that if an employee needs to be removed, they are removed from the schedule and to make sure it was addressed timely.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating dated 9/2023, revealed 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 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 .</p> <p>NJAC 8:39-9.4 (f)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>38327</p> <p>Based on the interview, record review, and review of pertinent facility documentation it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of the 28 residents reviewed, Resident #147.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 4/22/24 at 9:49 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM informed the surveyor that Resident #147 was on contact precaution for C. diff (also known as Clostridioides difficile or C. difficile, is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon).</p> <p>On 4/22/24 at 10:04 AM, the surveyor observed Resident #147's room with a posted sign for contact precaution and PPE (personal protective equipment) hung outside the door. The resident was seated in a wheelchair with a responsible party (RP) inside the room wearing gloves and a gown. The resident had no roommate.</p> <p>During an interview, the RP informed the surveyor that he/she visits the resident daily. The RP was aware of the resident's C. diff and the precautions. The RP further stated that the resident had been in the room with no other residents, not sure exact date, but probably beginning of April 2024.</p> <p>The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #147 as follows:</p> <p>According to the Admission Record (admission summary), Resident #147 was admitted to the facility with a diagnosis that included but was not limited to essential hypertension (abnormally high blood pressure that's not the result of a medical condition), dementia (group of thinking and social symptoms that interferes with daily functioning) in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, type 2 diabetes mellitus without complications, and diarrhea unspecified.</p> <p>A review of the resident's Progress Notes (PN) showed the following information:</p> <p>Created date 4/07/24 at 8:00 PM by Licensed Practical Nurse (LPN) included that Resident #147 isolation precautions maintained.</p> <p>Created date 4/9/2024 at 7:16 AM by Registered Nurse #1 (RN#1) included that isolation precautions maintained.</p> <p>Created date 4/9/2024 at 9:43 AM by the physician, included in the documentation that the patient (also known as the resident) seen for stool positive for C.Diff Colitis. The Impression and Plan included: C.Diff Colitis-On oral Vanco (antibiotic) 250 mg (milligrams) po (by mouth) q6hrs (every 6 hours) x 2 weeks then tid (3 x a day), bid (twice a day) and daily 1 week each.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Created date 4/9/2024 at 6:24 PM by RN#2 documented that resident stool specimen result showed positive for C. diff, RP and physician were made aware. It also included in the documentation of RN#2 that the physician ordered to start contact isolation and the resident was transferred to a private room.</p> <p>A review of the resident's laboratory (lab) reports showed that on 4/09/24 at 01:59 PM, the final positive result for C. diff was called and read to the facility.</p> <p>The resident's quarterly MDS (qMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/09/24 revealed in Section C Cognitive Status with a BIMS (Brief Interview for Mental Status) score of 3 which reflected that the resident's cognitive status was severely impaired. The qMDS in Section O Special Treatments, Procedures, and Programs: isolation or quarantine, was coded no which indicated that the resident was not in isolation or quarantine.</p> <p>On 5/01/24 at 9:44 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDSC). The RN/MDSC informed the surveyor that the facility did not have a policy for MDS, instead, the facility followed the RAI (Resident Assessment Instrument) Manual. The RN/MDSC stated that isolation would be coded in MDS Section O when the criteria were met for isolation during the lookback period. She further stated that she looked at the resident's medical records for the documentation with regard to the isolation of nurses, physicians, and another interdisciplinary team (IDT) like the social workers, dietitians, and therapists. She also stated that the criteria were resident in a single isolation room, contact precautions that included COVID-19 and C. diff, and airborne, diagnosis of shingles (a viral infection that causes a painful rash).</p> <p>On that same date and time, the surveyor notified the RN/MDSC of the above findings and concerns that the 4/09/24 qMDS was not coded for isolation. The RN/MDSC stated that the resident did not meet the criteria for isolation according to the RAI Manual. The surveyor then asked the RN/MDSC to provide a copy of the RAI Manual that reflected that 4/09/24 should not be coded for isolation, and the RN/MDSC stated that she would get back to the surveyor. She further stated that she would also have to call the Regional MDS person.</p> <p>On 5/01/24 at 12:17 PM, the RN/MDSC notified the surveyor that she provided a copy of the modified qMDS with an ARD of 4/09/24 to reflect the isolation in Section O of the MDS. The RN/MDSC informed the surveyor that the isolation should have been captured in the 4/09/24 qMDS. The RN/MDSC acknowledged that the 4/09/24 qMDS was not accurately coded.</p> <p>On 5/01/24 at 01:01 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), [NAME] President of Clinical (VPoC), and Administrator in Training (AIT). The surveyor notified the facility management of the above concerns and findings.</p> <p>A review of the provided CMS's RAI Version 3.0 Manual dated October 2023 that was provided by the RN/MDSC included in O0110: Special Treatments, Procedures, and Programs, Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)</p> <p>Code only when the resident requires transmission-based precautions and single room isolation (alone in a separate room) because of active infection (i.e., symptomatic and/or have a positive test and are in the contagious stage) with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Code for single room isolation only when all of the following conditions are met:</p> <ol style="list-style-type: none"> 1. The resident has active infection with highly transmissible or epidemiologically significant pathogens that have been acquired by physical contact or airborne or droplet transmission. 2. Precautions are over and above standard precautions. That is, transmission-based precautions (contact, droplet, and/or airborne) must be in effect. 3. The resident is in a room alone because of active infection and cannot have a roommate. This means that the resident must be in the room alone and not cohorted with a roommate regardless of whether the roommate has a similar active infection that requires isolation. <p>On 5/02/24 at 9:52 AM, the survey team met with the LNHA, DON, VPoC, AIT, and the Director of Rehab. The VPoC stated that the MDS of Resident #147 should have been coded for isolation.</p> <p>NJAC 8:39-11.2(e)(1,2)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>38327</p> <p>REPEAT DEFICIENCY</p> <p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) follow physician's orders (PO), b.) ensure an individualized comprehensive care plan and interventions were developed and implemented, c.) ensure that the weekly skin review assessment was accurate, and d.) appropriately perform infection control practices during wound treatment observation in accordance to standards of clinical practice, CDC (Centers for Disease Control and Prevention) guidelines, and facility's policy and procedure. This deficient practice was identified for one (1) of five (5) residents (Resident # 122) reviewed for pressure ulcers.</p> <p>The deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>According to CDC Hand Hygiene in Healthcare Settings, Hand Hygiene Guidance, Last Reviewed: January 30, 2020. The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations include the following strong recommendations for hand hygiene in healthcare settings.</p> <p>Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:</p> <p>Immediately before touching a patient</p> <p>Before moving from work on a soiled body site to a clean body site on the same patient</p> <p>After touching a patient or the patient ' s immediate environment</p> <p>After contact with blood, body fluids, or contaminated surfaces</p> <p>Immediately after glove removal.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/22/24 at 9:49 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM informed the surveyor that Resident # 122 had a facility-acquired wound to the sacrum. The RN/UM stated that the resident was also on Enhanced Barrier Precautions (EBP) wherein the staff and visitors were expected to use PPE when providing direct care like feeding, bathing, wound care, and transferring. She further stated that isolation gowns and gloves were the PPE to use when providing direct care to residents on EBP including Resident #122 because of the wound in the sacrum.</p> <p>On 4/22/24 at 9:58 AM, the surveyor observed Resident # 122's room with a posted sign for EBP and there were PPE supplies hung outside the door. There was also an ABHR (alcohol-based hand rub) mounted on the wall outside the door of the resident. Upon entry to the resident's room, there was a covered bin.</p> <p>The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #122.</p> <p>According to the Admission Record (admission summary), Resident #122 was admitted to the facility with a diagnosis that included but was not limited to encounter for palliative care (specialized medical care for people living with a serious illness), essential hypertension (abnormally high blood pressure that's not the result of a medical condition), basal cell carcinoma (type of skin cancer) of skin of other parts of face, hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), moderate protein-calorie malnutrition, gout unspecified (characterized by sudden, severe attacks of pain, swelling, redness, and tenderness in one or more joints, most often in the big toe), major depressive disorder.</p> <p>The resident's Significant Change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 3/15/24 revealed in Section C Cognitive Status with a BIMS (Brief Interview for Mental Status) score of 9 which reflected that the resident's cognitive status was moderately impaired.</p> <p>A review of the facility's Wound Investigation Report (WIR) that was provided by the Director of Nursing (DON) revealed that the facility discovered Resident #122's coccyx (also known as the tailbone) with DTI (deep tissue injury, purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear) 1 cm (centimeter) x 2 cm x 0 cm and coccyx stage two 3 cm x 1 cm x 0 cm. The WIR also included that the wound was unavoidable due to muscle wasting, poor appetite, immobility, fragile skin, weight loss, and multiple comorbidities. The resident was also in hospice care.</p> <p>Further review of the WIR showed that the coccyx wound was being monitored weekly as seen on dates 3/27/24, 4/03/24, 4/10/24, and 4/17/24. The 4/17/24 weekly monitoring revealed that the coccyx wound was unstageable, improving, and receiving ultrasound mist (a painless, bioactive therapy that promotes healing through cell stimulation while reducing bacterial load).</p> <p>The 4/17/24 wound care visit note that was electronically signed by CWSP (Certified Wound Specialist Physician) on 4/18/24 at 5:51 PM included that the coccyx pressure ulcer wound was improving, no debridement was performed as the resident received ultrasound mist.</p> <p>A review of the personalized Care Plan (CP) revealed that the coccyx wound was not identified, there was no target goal, and no interventions that focused on the coccyx facility-acquired wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Weekly Skin Review (WSR) that was provided by the DON included the following:</p> <p>3/29/24 Skin condition: treatment (tx) to forehead, right shin, and bunion ongoing.</p> <p>4/23/24 Skin condition: pre-existing wound on right forehead tx in progress, no new skin breakdown noted, right buttock and right bunion treatment in place.</p> <p>Further review of the above WSR showed that the coccyx pressure wound was not included.</p> <p>A review of the Order Summary Report (OSR) that was provided by the DON for April 2024 included the following PO:</p> <p>Active order 4/22/24 Resident requires EBP for a diagnosis of wound every shift.</p> <p>Active order 4/24/24 Santyl (approved prescription medicine that removes dead tissue from wounds so they can start to heal) external ointment 250 unit/gm (gram) apply to coccyx topically every shift for wound tx, cleanse the wound with Vashe (helps to cleanse the wound and work toward wound bed preparation). Apply santyl ointment. Apply Calcium alginate (a highly absorptive dressing). Apply Vitamin (Vit) A&D (used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations) ointment to periwound (the area around the wound), and cover the entire area with an ABD (abdominal) pad.</p> <p>The above PO for the coccyx wound and EBP were transcribed in the April 2024 electronic Treatment Administration Record (eTAR).</p> <p>On 4/25/24 at 10:26 AM, the surveyor observed Registered Nurse #1 (RN#1) perform a wound tx to Resident #122's coccyx with the assistance of RN#2. There was an EBP posted sign and PPE hung outside the resident's room. RN#1 entered the resident's room without performing hand hygiene as instructed in the posted sign to perform hand hygiene before entering the room. RN#1 informed the resident of the procedure (wound care) and assessed for pain. Both RN#1 and #2 entered the resident's room with isolation gowns and gloves. RN#1 prepared all the supplies and medications (meds) for wound tx while RN#2 repositioned the resident. RN#1's isolation gown was not properly tied at the back, when RN#1 turned toward the resident, RN#1's back exposed uniform directly touched the side of the table where the clean field was with tx supplies and meds that included the Vashe solution in a 6 ounces (oz) cup and Santyl ointment in a 30 cc (cubic centimeter) cup.</p> <p>Then, RN#1 took 4 x 4 gauze wet it with Vashe, and cleansed the wound twice. RN#1's gloves were wet with Vashe solution from wound cleaning and dried the wound with another 4 x 4 gauze. After cleaning the wound, RN#1 did not change gloves and did not perform hand hygiene, immediately took the tongue depressor to get the santyl, applied the santyl to the wound, applied the calcium alginate, and covered it with an ABD pad. RN#1 doffed off (removed) gloves, disposed of all supplies in the garbage, and performed hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Afterward, RN#1 while inside the room informed the resident that RN#1 returned the resident's cell phone and a cup of water to the top of the resident's table and placed them near the resident's bed easily accessible to the resident. The surveyor observed RN#1 place the cell phone and water container with her bare hands. RN#1 exited the resident's room without performing hand hygiene after touching the resident's personal items, directly went to the computer just outside the resident's room in the tx cart, signed the eTAR, and documented the coccyx wound tx done to Resident #122.</p> <p>RN#1 did not follow the EBP posted sign that everyone must clean their hands, including before entering and when leaving the room.</p> <p>RN#1 did not follow the PO to apply Vit A&D to the periwound area.</p> <p>On 4/25/24 at 10:53 AM, the surveyor interviewed RN#1 outside the resident's room and RN#1 informed the surveyor that she was done with wound tx. While interviewing RN#1, RN#2 came back and joined the interview. During an interview, RN#1 informed the surveyor that she was an agency nurse, and usually worked in the facility Monday, Tuesday, Friday, and some Saturday. RN#1 stated that today she came to work because she was available. RN#1 stated that she received in-service, education about infection control that included PPE, hand hygiene, and wound tx by the facility's Assistant Director of Nursing (ADON) and Infection Preventionist Nurse (IPN). RN#1 also stated that she was aware and as per education, hand hygiene should be done before and after PPE use and donning (putting on) and doffing of gloves.</p> <p>At that same time, the surveyor notified the nurses (RN#1 and #2) of the above findings and concerns. Both nurses acknowledged that RN#1 should have done hand hygiene before and after removing gloves, and when RN#1 cleansed the wound, the nurse should have removed gloves and performed hand hygiene. RN#1 acknowledged also that the EBP sign should have been followed to perform hand hygiene before and after entering the room.</p> <p>Furthermore, RN#1 stated that the coccyx wound was considered facility acquired wound, with preventative wound care prior to the development of the wound, being followed by the wound team, and that the wound was getting better.</p> <p>On 4/25/24 at 11:36 AM, the surveyor asked RN#1 regarding the PO for wound tx to the coccyx area and why she did not follow the order to apply Vit A&D ointment to periwound prior to covering the wound with an ABD pad. RN#1 checked the order on the computer and stated that she should have followed the order for Vit A&D but it was missed. She acknowledged that Vit A&D was part of the order for coccyx wound tx and it was missed.</p> <p>On 4/29/24 at 9:18 AM, the surveyor interviewed the Infection Preventionist/Licensed Practical Nurse (IP/LPN) in the presence of the survey team. The surveyor notified the IP/LPN of the above findings and concerns. The IP/LPN stated that it was an expectation for RN#1 to perform hand hygiene after cleaning the wound, after touching the resident's personal items, and followed the PO for coccyx. She further stated that RN#1 should have followed the EBP posted sign that they should perform hand hygiene before and after exiting the resident's room according to the facility's practice and policy.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/01/24 at 9:35 AM, the surveyor interviewed the RN/UM regarding CP. The RN/UM informed the surveyor that the CP initiation and revision was her responsibility including the resident's wounds and other care areas. The RN/UM stated that the CP should be initiated at the time of identification of the wound and revised or updated when the wound was resolved. She further stated that at most should be initiated on the same date, the following day, or if on a weekend, on Monday when I come in I will update or initiate the care plan.</p> <p>On that same date and time, the surveyor notified the RN/UM of the above findings regarding the resident's CP and that there was no care plan for the facility-acquired wound coccyx of the resident. The RN/UM showed in the electronic medical record the focus CP for skin impairment and at risk for further skin breakdown related to impaired mobility that was initiated on 5/18/23 and revised on 11/20/23. The surveyor asked the RN/UM why there was no CP focus on the coccyx pressure wound identified on 3/21/24, and the RN/UM had no response.</p> <p>Later on, the RN/UM stated that she acknowledged that the CP should have been personalized, and with goals and interventions according to the identified problem.</p> <p>On 5/01/24 at 01:01 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, [NAME] President of Clinical (VPoC), and Administrator In Training (AIT). The surveyor notified the facility management of the concerns with Resident #122.</p> <p>A review of the provided facility's Care Plans, Comprehensive Person-Centered policy that was provided by the VPoC with an updated date of 10/2023 included that a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan will: incorporate problem areas; incorporate risk factors associated with identified problems; and reflect treatment goals, timetables, and objectives in measurable outcomes. The areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan. When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers.</p> <p>A review of the provided facility's Enhanced Barrier Precautions Policy and Procedure with a revision date of 7/22/23 that was provided by the IP/LPN included that EBP will be implemented (when contact precautions do not otherwise apply) for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO (Multidrug-resistant organisms) colonization status and infection or colonization with an MDRO. EBP expands the use of PPE and refers to the use of gowns and gloves during high-contact resident care activities that provide opportunities for the transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high-contact care activities. Implementation (where applicable): clear signage must be posted on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g. gown and gloves). For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gowns and gloves. PPE, including gowns and gloves, must be available immediately outside of the resident room. Access to alcohol-based hand rub is required in every resident room (ideally both inside and outside of the room). A trash can must be positioned inside the resident's room and near the exit for discarding PPE after removal, prior to exit of the room, or before providing care for another resident in the same room.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/02/24 at 9:12 AM, the surveyor notified the DON in the presence of the VPoC and LNHA regarding WSR for March 2024 and April 2024 discrepancy and non-identification of coccyx facility-acquired wound.</p> <p>On 5/02/24 at 9:52 AM, the survey team met with the Director of Rehab, DON, LNHA, AIT, and VPoC. The VPoC acknowledged the above findings and concerns. The VPoC stated that the WSR was being done by nurses during the shower schedule of the resident once a week, the nurse does the body assessment, and notes if the nurse found new skin injuries including the existing wounds. The VPoC stated that the WSR should be accurate.</p> <p>At that same time, the VPoC acknowledged that the CP should be specific because the resident had multiple wounds, and the wounds were other skin impairments, cancer wounds, and pressure ulcers that included the coccyx wound.</p> <p>NJAC 8:39-27.1 (a)(e), 33.2(d)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885</p> <p>Based on observations, interviews, review of the medical record and review of other facility documentation, it was determined that the facility failed to ensure that residents with decreased range of motion and mobility received treatments to prevent contractures or further contraction specifically by a) not following a Functional Maintenance Program (FMP) recommendation for splints for 1 of 3 residents reviewed for position and mobility (Resident #20); and b) not following a FMP recommendation for range of motion (ROM) for 1 of 3 resident's reviewed for position and mobility (Resident #112).</p> <p>The deficient practice was evidenced by the following:</p> <p>1. On 4/22/24 at 10:50 AM, the surveyor observed Resident #20 seated in a reclined wheelchair in the fourth floor unit dayroom. The surveyor observed that Resident #20's hands and arms were contracted (A permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). The surveyor did not observe any splints on the resident's hands or arms.</p> <p>On 4/22/24 at 10:52 AM, the surveyor interviewed Resident #20's parent, who stated that the resident resided at the facility for 11 or [AGE] years. Resident #20's parent stated that the resident had splints but was not sure when therapy came to put them on. Resident #20's parent pointed to blueish gray splints that were on the bottom shelf of a shelving unit across from the end of Resident #20's bed.</p> <p>A review of Resident #20's Admission Record (AR) face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: quadriplegia (relating to paralysis of all four limb) and anoxic brain damage (injuries that completely cut off the oxygen supply to the brain).</p> <p>A review of Resident #20's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/30/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated that Resident #20's cognition was severely impaired. Further review of the MDS did not indicate the resident had splint or brace assistance.</p> <p>A review of Resident #20's April 2024 Medication Administration Record and Treatment Administration Record (MAR/TAR) included the following orders:</p> <p>FMP (Functional Maintenance Program): Apply B/L (bilateral) Elbow Braces - On in PM; off in AM. As Tolerated. Check skin prior to application and when removing. every evening and night shift with an order date of 4/22/24.</p> <p>FMP: Apply Left Resting Hand Splint - On in AM; off in PM. As Tolerated. Check skin prior to application and when removing. every day and evening shift with an order date of 4/22/24.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/24/24 at 11:46 AM, the surveyor interviewed Resident #20's Certified Nursing Assistant (CNA) #1. CNA #1 stated that Resident #20 had contractures and wore a splint on the wrist that the FMP CNA placed on the resident. CNA #1 stated that she did not apply or remove Resident #20's splints.</p> <p>On 4/24/24 at 01:48 PM, the surveyor interviewed the Lead Therapist. The Lead Therapist stated that the process for a resident that had a contracture or had a contracture that was getting worse would be that nursing would send a referral and that therapy would perform an evaluation and then give a recommendation. The Lead Therapist then stated that the therapist would attempt to splint during treatment and that if the resident could tolerate the splint then the therapist would educate the staff. The Lead Therapist stated that when the resident was discharged from therapy that nursing would follow up. She added that nursing put the order in the computer. The Lead Therapist stated that the splinting would be done by the CNA and that the facility's FMP CNA did not do splints. The Lead Therapist stated that Resident #20 had been referred for contracture recently and that the resident was discharged on [DATE]. She added that a FMP form was given to nursing which provide information on FMP.</p> <p>On 4/24/24 at 01:55 PM, the surveyor interviewed the Occupational Therapist (OT). The OT stated that Resident #20 was recently seen for the goal of call bell access. He added that historically Resident #20 was seen for splints but the last time was not for splints. The OT stated that we make nursing aware that the resident has them if the resident used them previously. He added that we communicate to the staff how to put them on and how often they were to be applied. The OT stated that we give a FMP form and have the nurse sign it. He added that the order for splints should be implemented as soon as the resident is discharged from services.</p> <p>On 4/25/24 at 9:05 AM, the surveyor interviewed Registered Nurse (RN) #1. RN #1 stated that FMP documentation would be in the electronic medical record and that there was not a separate paper binder. RN #1 stated that for splints, the FMP CNA and the nurse would apply them.</p> <p>On 4/25/24 at 9:15 AM, the surveyor interviewed the FMP CNA. FMP CNA stated that after a resident finished skilled rehabilitation services that she would walk with residents. She stated that the nurses would apply the splints and that she would check and if the nurse did not apply the splint then she would apply the splint. FMP CNA stated that she would document in the electronic medical record for the splints.</p> <p>On 4/25/24 at 9:25 AM, the surveyor interviewed CNA #2. CNA #2 stated that Resident #20 had contractures and had a splint for the hand applied in the morning. CNA #2 stated that she would apply the splint if the FMP CNA or nurse did not apply the splint. CNA #2 stated that she would document in the electronic medical record for the splints.</p> <p>On 4/25/24 at 10:50 AM, the Lead Therapist provided the surveyor Resident #20's FMP forms and Discharge Summaries. The Lead Therapist stated that Resident #20 had the right hand splint discontinued during the last OT skilled rehabilitation service so the resident could use the call bell. The surveyor asked how soon after the date on the FMP form should the order and application of splint be. The Lead Therapist stated that we put a start date on the FMP form and they should start it within a day or two. She added that staff were inserviced and that a nurse and CNA would sign the form.</p> <p>A review of the facility provided OT Therapy Discharge Summary indicated Resident #20 had received skill rehabilitation services from 2/6/24 to 4/11/24 and included the following:</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Discharge Recommendations and Status: .Functional Maintenance-Splint and Brace Program Established/Trained: B (bilateral) elbow splints and Resting hand splints. The FMP form, with a start date of 4/12/24, included the following:</p> <p>Splinting/Bracing: Left and Right elbow brace and Left resting hand splint. Resting hand splint (on am off pm)</p> <p>Elbow brace (on pm off am)</p> <p>The form was signed by a therapist, a CNA and a nurse on 4/11/24.</p> <p>A review of the facility provided PT (Physical Therapy) Discharge Summary indicated Resident #20 had received skill rehabilitation services from 11/16/23 to 12/27/23. The FMP nursing instruction form, with a start date of 12/28/23, included the following:</p> <p>Splinting/Bracing: comfy elbow splints b/l (bilateral), R (right) resting hand splint and L (left) hand grip splint as per prior FMP.</p> <p>The form was signed by a therapist, a CNA and a nurse on 4/11/24.</p> <p>A review of Resident #20's December 2023, January 2024 and February 2024 MAR/TAR did not include an order for FMP for splints during the time period that the resident was not receiving skilled rehabilitation services which was 12/28/23 to 2/5/24.</p> <p>On 4/25/24 at 11:42 AM, in the presence of another surveyor, the surveyor interviewed the Director of Nursing (DON) and PT Lead regarding the FMP program in regards to splints for contractures. The DON stated that the facility had a FMP program for residents after the resident was discharged from skilled rehabilitation services to make sure the resident does not decline and the function continued. The DON stated that the FMP CNA and nurse apply the splints and that they are trained. The DON stated that when a resident was finished with skilled rehabilitation services, the therapist would give an alert form for FMP to the unit manager which would have directions for the splint(s). The DON stated that CNAs were trained and that they would sign a paper for the training. The DON stated that there would be an order for the splint(s) in the electronic medical record and it would also be in the Task section for the CNAs. The surveyor asked if a splint order would be continued when a resident was on skilled rehabilitation services. The DON stated that it would be discussed with the Director of Rehab. She added that splinting was usually discontinued during the skilled rehabilitation service time period. The DON then stated that when the services were discontinued the therapy department would give the FMP form for splinting and it should be done in one or two days if we need to clarify anything. The Lead Therapist added that if there is any confusion it may not be done right away but there should be documentation.</p> <p>A review of the facility provided Documentation Survey Report (documentation of the Intervention(s)/Task(s) performed by the CNA for each day of the month) for April 2024 for Resident #20 included the following:</p> <p>Apply splinting device(s), per order FMP, Apply R and L comfy elbow splint on in PM, off in AM or as tolerated The intervention/task was started on 4/22/24.</p> <p>(continued on next page)</p>

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>FMP: Apply left resting hand splint-on in AM, off in PM, as tolerated .The intervention/task was started on 4/22/24.</p> <p>There was no documentation that Resident #20 had any splint(s) applied from 4/12/24 to 4/22/24.</p> <p>Further review of the facility provided Documentation Survey Report for Resident #20 for January 2024 and February 2024 did not include any intervention/task for splint(s) to be applied. There was no documentation that Resident #20 had any splint(s) applied for the time period that the resident was not receiving skilled rehabilitation services (1/1/24 to 2/6/24).</p> <p>On 4/25/24 at 01:04 PM, the surveyor interviewed the agency LPN. The agency LPN stated that she had one resident that had a splint. She added that she would apply the splint to the resident. The agency LPN stated that when the resident was discharged from services, therapy department would give us a form and we would sign off on the form.</p> <p>On 4/25/24 at 01:09 PM, the surveyor interviewed the Unit Manager/ Licensed Practical Nurse (UM/LPN) of the fourth floor unit. The UM/LPN stated that splint application would be done by FMP CNA or the resident's CNA and the nurse would have to check the skin. She added that both CNAs and nurses had to sign off on splinting. The UM/LPN stated that she would receive a form from the therapist and that she would put the order in the computer, update the task section and update the care plan. The surveyor asked the UM/LPN the reason why there was a delay in Resident #20's FMP for splint order placed in the computer. The UM/LPN stated that she did not agree with the FMP order and that she needed the order clarified. The UM/LPN stated that she originally had received a different alert form that had the timing of both splints to be placed in the AM and that they both could not be applied at the same time. The UM/LPN stated that she received the new form on Monday (4/22/24) and placed the order in the computer. She added that the form still had the original date (4/12/24) on it. The surveyor asked if there was any documentation that the order had to be clarified. The UM/LPN stated that she did not document anywhere that she had to clarify the order. The surveyor then asked the UM/LPN the reason why there was not an order for FMP for splint(s) for the time period of 12/28/23 to 2/5/24 when Resident #20 was not receiving skilled rehabilitation services. The UM/LPN stated that she did not remember the issue. The surveyor asked if there should be an order for splints for that time period. The UM/LPN stated that there would not be if we did not receive a recommendation. She added that she did not remember if she received one. The UM/LPN then stated that she was supposed to sign the bottom of the form but that she did not sign the 4/12/24 form.</p> <p>On 5/01/24 at 8:12 AM, the surveyor interviewed the DON regarding Resident #20 and splints. The DON stated that she talked to the UM/LPN and that she was not able to put the order in when given the recommendation because she had questions about the order. The DON stated that the OT took a while to get back to the UM/LPN but that it should not have taken that long. The surveyor asked the DON what the importance of splinting was. The DON stated that it was to prevent contracture or if there already was a contracture to prevent further decline and maintain the function.</p> <p>On 5/01/24 at 01:04 PM, in the presence of the survey team, the surveyor told the Licensed Nursing Home Administrator (LNHA), Administrator in Training (AIT), DON and VP of Clinical (VPC) the concern that Resident #20 did not have an order for splinting and there was no documented evidence that the resident had any splints applied when the resident was not receiving skilled rehabilitation services.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/02/24 at 9:52 AM, in the presence of the survey team, LNHA, DON, AIT and Director of Rehab (DR), the VPC stated that rehab was working with the resident until the resident was discharged from services on 4/12/24. The VPC stated that nursing did not sign for the 10 days because they were clarifying the order. The DR stated that they were trying to see if a different splint could be used for the whole arm since the two splints over ride each other when both splints were applied to one arm. He added that we then decided to do an alternate schedule. The surveyor then asked about the time period of 12/28/23 to 2/5/24 where there was no order for splints or documented evidence that the splints were applied. The VPC confirmed that there was no order for the splints or any documentation that the splints were applied and that there should have been. The VPC also confirmed that in April 2024, there was a verbal discussion about the clarification of the order but that there was no documentation of the discussion. She added that there should have been documentation in the medical record for the clarification.</p> <p>The facility did not provide any additional information.</p> <p>41858</p> <p>2. On 04/22/24 at 11:48 AM, during the initial tour of the NA 2nd floor unit, the surveyor observed Resident #25 in the activity room. The resident's eyes were closed. The surveyor was unable to interview the resident.</p> <p>On 04/24/24 at 9:52 AM, the surveyor observed Resident #25 out of bed in a reclining chair in the activity room. The resident was unavailable for interview.</p> <p>The surveyor reviewed Resident #25's electronic Medical Record (eMR).</p> <p>A review of the AR revealed that the resident was admitted to the facility with diagnoses which included but were not limited to:</p> <p>Unspecified Dementia, (a term used to describe a group of symptoms affecting memory, thinking and social abilities) Unspecified Severity, with agitation and schizoaffective disorder (a mental health disorder that is marked by a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms) Bipolar Type (a mental health condition that causes extreme mood swings that include emotional highs).</p> <p>A review of the quarterly MDS, dated [DATE], revealed the resident had a BIMS of 00 out of 15, which indicated that the resident's cognition was severely impaired. Further review revealed the resident had impairment of the upper extremity, one side and lower extremities, both sides.</p> <p>A review of the physician's Order Summary Report revealed a physician's order (PO) dated 3/9/2022 FMP PROM (passive range of motion) to both upper/lower extremities 2x10 for all joints and planes as tolerated.</p> <p>A review of the ongoing care plan (CP) revealed a Focus: [name redacted] will maintain current level of function through the</p> <p>review date. Date Initiated: 04/10/2024, Revision on: 04/10/2024.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the CP revealed a Focus: [name redacted] on Functional Maintenance Program Date Initiated: 03/09/2022 and a Focus: [name redacted] will maintain strength and ROM Date Initiated: 03/09/2022, Revision on: 04/20/2023, Target Date: 06/17/2024.</p> <p>A review of the progress note dated 4/2/2024 at 12:34, revealed: General Note, Note Text: Team met to discuss [name redacted] Quarterly progress.Requires total care with ADLS and bed mobility .On FMP for PROM .</p> <p>A review of the Certified Nursing Assistant (CNA) Tasks revealed a Task: FMP: PROM to both upper/lower extremities 2x10 for all joints and planes as tolerated revealed that CNA #3 had checked the Resident actively participated on the day shift (7 to3) for 4/2/24, 4/3/24, 4/10/24, 4/11/24, 4/12/24, 4/17/24, 4/18/24, 4/20/24, and 4/24/24.</p> <p>Further review of the Certified Nursing Assistant (CNA) Tasks revealed a Task: FMP: PROM to both upper/lower extremities 2x10 for all joints and planes as tolerated revealed that CNA #4 had checked on the day shift not applicable on 4/8/24, 4/15/24, 4/16/24, 4/22/24, and 4/23/24. Additional days that not applicable was checked was: 3/27/24, 3/28/24, 3/29/24, 3/30/24, 4/1/24, 4/4/24, 4/5/24, 4/13/24, 4/19/24, 4/21/24. This review revealed that not applicable was checked 15 times in the Task Look Back: 30 (days).</p> <p>On 04/25/24 at 10:06 AM, the surveyor interviewed resident #25's assigned licensed practical nurse (LPN) #1, who stated that the FMP aide does the FMP ROM. She stated the purpose of FMP was to help resident's maintain their function.</p> <p>On 04/25/24 at 10:32 AM, the surveyor interviewed Resident # 25's assigned CNA#3, who stated that the resident was total dependence for activities of daily living. She was unable to explain what the resident's FMP ROM was or why she checked that the resident had actively participated. She stated that the FMP ROM was done by the FMP aide.</p> <p>On 4/25/24 at10:38 AM, the surveyor interviewed the Registered Nurse/ NA-2 Unit Manager (RN/UM), who stated that the FMP aid was responsible for the ROM for the residents. She was unable to explain why not applicable was checked or if the FMP ROM was performed on those days.</p> <p>On 04/25/24 10:50 AM, the surveyor interviewed the FMP CNA (FCNA), who stated she was responsible for ambulating (walking) the residents. She stated she does not do the resident's FMP ROM and that the assigned CNA does it.</p> <p>On 04/25/24 at 11:42 AM, the surveyors interviewed the Director of Nursing (DON) and the Lead Physical Therapist (LPT). The DON stated that the restorative program had a dedicated FCNA that was responsible for ambulation. She stated that ROM was done by the assigned CNA not the FCNA. The DON stated the FMP ROM was part of the CNA's tasks. The LPT stated, after skilled rehabilitation services they put residents on FMP to make sure they do not decline in function.</p> <p>On 4/29/24 at 11:15 AM, the surveyor interviewed CNA #4 in regard to what not applicable meant. CNA #4 stated, if you select not applicable, it means you're not doing what you're supposed to do. I would never say I didn't do it. When the surveyor reviewed the above dates that she checked not applicable, she stated, it was a big error, it was a mistake. She was unable to explain the required FMP ROM exercises for the resident.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/29/24 at 12:22 PM, during an interview with the [NAME] President of Clinical and the DON, the VPC stated we have identified areas that need improvement. She further stated, not applicable should not be there, it should not be checked.</p> <p>On 5/1/24 at 1:00 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA), the Administrator in training (AIT), the [NAME] President of Clinical (VPC), and the DON, the surveyor presented the above concerns for Resident #25.</p> <p>On 5/2/24 at 10:03 AM, during a meeting with the survey team, the LNHA, the AIT, the DON, and the RD, the VPC stated, they (the facility) could not validate if it (FMP ROM) was getting done.</p> <p>A review of the facility Master Signature Sheet, Topic of Inservice: Splinting, FMP, Ambulation, ROM dated 10/25/23 revealed that CNA #3, the RN/UM, the LPN/UM, LPN #1, and RN#1 attended the 45 minute inservice.</p> <p>A review of the facility provided policy that was untitled with an updated date of 10/2021 included the following:</p> <p>Policy: Splints/Adaptive Devices are to be applied as ordered by physiatrist/attending physician/nurse practitioner. After a clinical review is completed the resident will be provide with an appropriate device as needed.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. MD orders PT/OT evaluation to determine the type of splint/adaptive device needed. Nursing may also ask for a screen to therapy to take a look at the resident. 2. Therapist contacts vendor to order splint/adaptive device. 3. Therapist obtains Physician order for splint/adaptive device application and fitting. 4. Therapist fits/adjust splint/adaptive devices. 5. Order is written for splint application/schedule-whether in therapy or on unit. Application is individualized after review with the Clinical team to include therapist, MD, nurse/CNA. The therapist will recommend a device as appropriate for resident. 6. Therapy in-services CNA's and Nursing Staff. A copy of the inservice is placed in the chart. Physiatrist/physician/nurse practitioner writes the order for the splint/adaptive device which is transcribed onto the POS/treatment record. 7. Splint schedule is made up in accordance with the order. This is based on the clinical need of such a device. 8. Splint/adaptive devices will be listed on the CA assignment also on Resident Care Plan. 9. The CNA's assigned to the unit are to monitor the splint application along with the nurses. <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10. The nursing staff must monitor the residents with adaptive dives (devices) for signs of redness/skin breakdown etc. and report abnormal findings to physician/nurse practitioner immediately for appropriate interventions.</p> <p>A review of the facility's untitled policy, revised April 2023, revealed:</p> <p>Procedure: For active range of motion exercises, follow the same procedure as passive range of motion exercises instructing the resident to perform the activities independently .Assist the resident as necessary and asses the resident's ability to perform active range of motion exercises.</p> <p>Documentation Guidelines</p> <p>Date, time, range of motion: part(s) exercised and type of range of motion.</p> <p>Amount of resident participation in procedure</p> <p>Notification of the physician of any condition changes</p> <p>Resident's progress toward care plan goals</p> <p>NJAC 8:39-27.1 (a)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>38327</p> <p>Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that staff provided adequate routine monitoring for a resident after returning from receiving offsite hemodialysis and provided care and services in accordance with professional standards clinical practice for one (1) of three (3) residents (Resident #22), reviewed for dialysis services.</p> <p>The deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>On 4/22/24 at 10:18 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of the N3 unit. The RN/UM informed the surveyor that Resident #22 was a hemodialysis (HD, is a process of filtering the blood of a person whose kidneys are not working normally) resident. The RN/UM stated that Resident #22 was out for HD, the HD was every Monday, Wednesday, and Friday at 5:30 AM pick-up time and comes back around 11 AM.</p> <p>The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #22.</p> <p>According to the Admission Record (admission summary), Resident #22 was admitted to the facility with a diagnosis that included but was not limited to essential hypertension (abnormally high blood pressure that's not the result of a medical condition), hydrocephalus (a build-up of fluid in the cavities deep within the brain) unspecified, diabetes mellitus (diabetes mellitus due to underlying condition with diabetic polyneuropathy) due to underlying condition with diabetic polyneuropathy, end-stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), and dependence on renal dialysis.</p> <p>The resident's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 4/06/24 revealed in Section C Cognitive Status with a BIMS (Brief Interview for Mental Status) score of 15 which reflected that the resident's cognitive status was intact. The cMDS revealed that the resident was on dialysis.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Roosevelt Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Parsonage Road Edison, NJ 08837	

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Nursing Facility/Dialysis Center Communication Record (NF/DCCR) that was in the N3 nursing station that was provided by the Unit Secretary showed the following:</p> <p>4/05/24, 4/08/24, 4/10/24, 4/15/24, 4/17/24, 4/19/24, and 4/22/24 did not include post dialysis vital signs (v/s, measure the basic functions of body. They include body temperature, blood pressure, pulse, and respiratory). There was no access site status documentation upon return from HD.</p> <p>4/01/24, 4/03/24, and 4/12/24 did not include access site status documentation upon return from HD.</p> <p>The Weights & Vitals (W&V) records in the electronic Medical Record (eMR) included the blood pressure summary for the following dates and times:</p> <p>4/05/24 at 4:59 AM, 4/05/24 at 02:34 PM, and 4/05/24 at 9:31 PM</p> <p>4/08/24 at 01:06 PM and 4/08/24 at 3:07 PM</p> <p>4/10/24 at 4:08 AM, 4/10/24, at 01:16 PM, 4/10/24 at 5:47 PM, and 4/10/24 at 8:45 PM</p> <p>4/15/24 at 3:10 AM, 4/15/24 at 11:35 AM, 4/15/24 at 02:55 PM, and 4/15/24 at 4:35 PM</p> <p>4/17/24 at 4:56 AM, 4/17/24 at 4:04 PM, and 4/17/24 at 6:29 PM</p> <p>4/19/24 at 5:12 AM, 4/19/24 at 4:09 PM, and 4/19/24 at 4:39 PM</p> <p>4/22/24 at 4:20 AM, and 4/22/24 at 4:11 PM</p> <p>A review of the Progress Notes (PN) revealed the following:</p> <p>Created date: 4/22/24 at 10:41 AM and electronically signed by the Licensed Practical Nurse (LPN) and documented that Temp (temperature): T 97.8 - 4/21/2024 17:33 (5:33 PM) Route: Axilla. Pulse: P 88 - 4/21/2024 17:33 Pulse Type: Regular. Resp (respiration): R 16.0 - 4/21/2024 17:33. BP (blood pressure): BP 96/54 - 4/22/2024 04:20 (4:20 AM) Position: Sitting l/arm (left/arm). BS (blood sugar): BS 135.0 - 4/11/2024 13:08 (01:08 PM). O2 Sat (oxygen saturation): O2 94.0 % - 4/21/2024 17:33 Method: Room Air. Resident back from HD at 10:40 AM.</p> <p>Created date: 4/17/2024 at 10:49 AM and electronically signed by LPN and documented that Temp: T 98.0 - 4/16/2024 14:09 (02:09 PM) Route: Forehead (non-contact). Pulse: P 74 - 4/16/2024 14:09 Pulse Type: Regular. Resp: R 17.0 - 4/16/2024 14:09. BP: BP 115/59 - 4/17/2024 04:56 (4:56 AM) Position: Other. BS: BS 135.0 - 4/11/2024 13:08 (01:08 PM). O2 Sat: O2 96.0 % - 4/15/2024 14:55 (02:55 PM) Method: Room Air. Resident back from HD at 10:45 AM.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/23/24 at 01:33 PM, the surveyor interviewed the LPN in the N3 unit. The LPN informed the surveyor that she was the agency nurse assigned to Resident #22, usually assigned in the N3 unit, and knew the resident. The surveyor asked the LPN about the facility's practice and protocol with regard to communication between HD and facility staff. The LPN informed the surveyor that the facility utilized the NF/DCCR wherein the top part of the paper was being documented by the facility's sending nurse the v/s, the condition of the resident, and access site of HD, any medications administered, and condition of the resident relevant for the HD nurse to know. The LPN stated that then the middle part of the paper was for the HD Center nurse's documentation, and the bottom part of the NF/DCCR paper was to be filled out by the receiving facility nurse's signature.</p> <p>On that same date and time, the surveyor asked the LPN what was the responsibility of the receiving facility nurse when the resident returned from HD. The LPN stated that the nurse should immediately check v/s, and assess the access site for bleeding when the resident returns from HD. The surveyor asked where the nurse should document, the LPN stated that it should be documented in the W&V tab in the eMR and those v/s will automatically transferred to the PN when the nurse documents the assessment and other relevant information.</p> <p>At that same time, the LPN showed the W&V records and did not reflect v/s for 4/22/24 when the resident came back from HD. The LPN informed the surveyor that she was the assigned nurse on the 7-3 shift when the resident came back from HD at 10:40 AM. LPN checked also the PN on 4/22/24 and showed that the v/s that were reflected were from 4/11/24 at 01:08 PM, 4/21/24 at 5:33 PM, and 4/22/24 at 4:20 AM. The LPN had no response when the surveyor asked the LPN why there was no documented v/s on 4/22/24 on her 7-3 shift.</p> <p>Later on, the surveyor asked the LPN if it was necessary to check the v/s and assess the resident upon return from HD and the LPN stated yes because the resident might bleed after dialysis.</p> <p>On 4/23/24 at 02:22 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team regarding the facility's policy and practice for HD communication. The DON stated that as per policy and expectation, the nurses take and document the resident's v/s in the HD communication paper (NF/DCCR) and the electronic Medication Administration Record (eMAR) or electronic Treatment Administration Record (eTAR) that they (nurses) checked the access site for HD immediately when the resident comes back from dialysis. The DON further stated that the order for access site check should be separate from every shift access site check. The DON further stated that it was important to check v/s and the access site because of possible bleeding and low BP after dialysis.</p> <p>At that time, the surveyor notified the DON of the above concerns and findings regarding the resident's HD communication paper with no v/s and access site documentation for seven (7) out of 10 HD days in April 2024.</p> <p>On 5/01/24 at 01:01 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, [NAME] President of Clinical (VPoC), and the Administrator in Training (AIT). The surveyor notified the facility management of the above concerns and findings with Resident #22.</p> <p>A review of the facility's Dialysis Patients Policy with a revised date of 11/2023 that was provided by the DON included post-dialysis protocol:</p> <p>Review transfer forms for any pertinent information.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Blood pressure prn (as needed)/daily or as the physician orders.</p> <p>Check the fistula for bruit (listening to the fistula) or feel for a thrill (by touching the fistula).</p> <p>On 5/02/24 at 9:52 AM, the survey team met with the Director of Rehab, DON, LNHA, AIT, and VPoC. The VPoC stated that prior to the surveyor's inquiry, the facility's process regarding dialysis communication between HD and the facility, the nurses were documenting in the NF/DCCR and eMR the v/s upon return from HD and found out that it was not being done routinely. She further stated that there were inconsistencies with the documentation of v/s and assessment of the access site, and the policy was not specific on what the nurses should be doing. The VPoC also stated that moving forward, the v/s and access site assessment will be documented in the eMAR.</p> <p>NJAC: 8:39-11.2(b), 27.1(a)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449</p> <p>Refer to F-760</p> <p>Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) accurate documentation of the removal of a controlled substance for 1 of 5 residents (Resident #12), reviewed for an as needed (PRN) 5/325 milligram (mg) of Oxycodone/Acetaminophen (a narcotic medication, indicated for pain), b.) accurate reconciliation and administration of narcotic medication with potential for drug diversion for 2 of 5 residents (Resident #12 and #212) reviewed for a PRN pain medicine, c.) discontinued narcotic medications were removed from active inventory and disposed of after being discontinued on 11/27/23 (5 months) for Resident #80. This deficient practice was observed during the inspection of one (1) of three (3) medication rooms, d.) a stored narcotic medication was maintained with the safety tamper seal (Resident #8), which was identified for one (1) of six (6) medication carts inspected, e.) clarify and accurately administer a medication (Midodrine) according to a physician's order identified for one (1) of seven (7) residents, (Resident# 148) reviewed for medication regimen review and f.) remove and dispose of controlled substances from active inventory when discontinued. This was identified for one (1) of seven (7) residents,(Resident #52) observed during medication administration.</p> <p>The deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.</p> <p>1. On 4/29/24 at 11:34, the surveyor and the Licensed Practical Nurse (LPN #1) began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box), located in the green side of the fourth floor</p> <p>At that time, in the presence of LPN #1, the surveyor observed the Controlled Substance Sheet Tally (CSST; a shift-to-shift count/signature for narcotic accountability) was signed daily until the day shift of April 29, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 11:50 AM, LPN #1 and the surveyor observed Resident #12's bingo card (blister packet which contains the medication) with a pharmacy label for Oxycodone /Acetaminophen (APAP) 5/ 325 mg (Percocet) tablets. The bingo card contained 7 tablets.</p> <p>At that time, in the presence of LPN #1, the surveyor compared the bingo card against Resident #12's Individual Patient's Controlled Drug Record (IPCDR; declining inventory sheet used to track removal of a controlled drug from inventory) for the Oxycodone/APAP 5/325 mg. The IPCDR log reflected a documented quantity of eight.</p> <p>At 11:53 AM, during an interview with the surveyor, LPN #1 stated she did not administer the medication that day. The surveyor asked why the missing tablet for Resident #12 was not identified during the CSST review between the two nurses that morning. LPN #1 stated I missed it.</p> <p>At 12:04 PM, during an interview with the surveyor, the LPN/ Unit Manager (UM) stated that the quantity in the bingo card should have matched the IPCDR for the resident.</p> <p>At 12:15 PM, during an interview with the surveyor, the LPN/UM stated that after the shift-to-shift count, the IPCDR and bingo card inventory count of the narcotic medication should match.</p> <p>At 12:17 PM, in the presence of LPN #1 and the LPN/UM, the surveyor interviewed Resident #12. The Resident was observed awake, lying in bed, and conversant. The resident stated that he/she often had left knee pain but tried not to take his/her Oxycodone/APAP 5/325 mg often. The resident stated he/she had not taken it that day but had taken the medication once yesterday (Sunday) and once the day before (Saturday). The resident had requested to also speak with the physician for a different matter.</p> <p>At that time, the LPN/UM stated that she would inform the Director of Nursing (DON).</p> <p>At 12:40 PM, during a meeting with the LPN/UM and the DON, the surveyor discussed the concerns regarding the one (1) missing tablet of Oxycodone/APAP 5/325 mg for Resident #12 on the fourth floor.</p> <p>At that time, the DON stated that Resident #12's missing Oxycodone/APAP 5/325 mg tablet from the bingo card should have been identified during the shift-to-shift count of the outgoing shift nurse (LPN #2) and the incoming shift nurse (LPN #1).</p> <p>On 4/30/23 at 9:40 AM, during a follow up interview with two surveyors and the Assistant Director of Nursing (ADON), the DON explained the process for the shift-shift count. The DON stated that the outgoing (end of shift) nurse and the incoming (start of shift) nurse compared the IPCDR against the bingo card for the inventory of each narcotic medication located in the narcotic box. The signatures on the shift-to-shift log meant that the on-hand inventory was correct. In the event, a narcotic count was incorrect the staff must notify the supervisor and me [the DON] when I am here, so we can investigate and ensure all the narcotics are accounted for.</p> <p>At that time, the DON stated that when a narcotic medication was to be administered, the nurse had to sign the IPCDR for the removal of the narcotic medication from the bingo card, and after the administration to the resident, the eMAR had to be signed.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At that time, the DON stated the Certified Consultant Pharmacist (CCP) visited the facility and checked the narcotics once a month.</p> <p>At that time, the DON informed the surveyors that based on her investigation, she learned that the outgoing nurse was looking at the IPCDR log only while the incoming Nurse LPN #1 who also admitted to only looking at the bingo card. Both nurses did not compare the IPCDR against the bingo card to check that the signature and the inventory count had matched. The DON submitted the signed document from both nurses attesting to the DON's explanation to the surveyors.</p> <p>At that time, the DON stated that both nurses were given education, a facility wide narcotic inventory for each medication storage was conducted, and a QAPI (Quality Assurance and Performance Improvement, a data driven and proactive approach to quality improvement) was initiated after surveyor inquiry.</p> <p>At that time, the DON stated that the outgoing nurse (LPN #2) wrote a statement that she had administered the Oxycodone/APAP 5/325 mg to Resident #12 on 4/29/24 at 1:55 AM and forgot to sign the IPCDR log but signed the eMAR.</p> <p>On 5/1/24 at 1:03 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator (LNHA), the Administrator in training (AIT), the VPC, and the DON, the surveyors discussed the concern regarding the failure of the facility's system of record keeping, to maintain an accurate inventory, and reconciliation of the Oxycodone 5/325 mg for Resident #12.</p> <p>On 5/2/24 at 9:52 AM, during a meeting with the survey team, the LNHA, the AIT, the DON, the Rehabilitation Director (RD), the VPC acknowledged the concerns.</p> <p>2. The surveyor reviewed the medical record for Resident #12.</p> <p>A review of Resident #12's Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to bilateral osteoarthritis of knee (a disease of deterioration of both knees) and left artificial knee joint (metal and or plastic device that is used to replace damaged knee joint).</p> <p>A review of Resident #12's most recent Comprehensive/Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/3/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated that the resident's cognition was intact.</p> <p>A review of the April 2024 electronic Medication Administration Record (eMAR) (used to accurately record residents' medication usage) reflected the following orders:</p> <p>-Oxycodone/APAP 5/325 mg, give 1 tablet by mouth every 6 hours as needed for moderate to severe joint pain, started on 2/7/24 and discontinued on 4/26/24.</p> <p>-Oxycodone/APAP 5/325mg, give 1 tablet by mouth every 6 hours as needed for moderate to severe joint pain, started on 4/26/24.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the eMAR against the IPCDR log for Oxycodone/APAP 5/325 mg reflected that the Oxycodone/APAP 5/325 mg was removed 13 times from inventory, logged as removed on the IPCDR however was not documented as administered on the eMAR on the following dates:</p> <ol style="list-style-type: none"> 1) On 4/8/24 at 1:00 AM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #2 and was not reflected as administered on the eMAR. 2) On 4/9/24 at 1:00 AM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #2 and was not reflected as administered on the eMAR. 3) On 4/9/24 at 5:00 PM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #1 and was not reflected as administered on the eMAR. 4) On 4/12/24 at 1:30 PM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #2 and was not reflected as administered on the eMAR. 5) On 4/12/24 at 11:00 PM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #1 and was not reflected as administered on the eMAR. 6) On 4/17/24 at 10:00 PM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #1 and was not reflected as administered on the eMAR. 7) On 4/19/24 at 12:30 AM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #2 and was not reflected as administered on the eMAR. 8) On 4/19/23 at 10:00 AM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #3 and was not reflected as administered on the eMAR. 9) On 4/19/24 at 8:00 PM, one (1) pill was documented as removed on the IPCDR from the bingo card by LPN #2 and was not reflected as administered on the eMAR. 10) On 4/22/24 at 2:30 PM, one pill (1) was documented as removed on the IPCDR from the bingo card by LPN #1 and was not reflected as administered on the eMAR. 11) On 4/23/24 at 2:00 AM, one pill (1) was documented as removed on the IPCDR from the bingo card by LPN #5 and was not reflected as administered on the eMAR. 12) On 4/26/23 at 8:20 PM, one pill (1) was documented as removed on the IPCDR from the bingo card by LPN #6 and was not reflected as administered on the eMAR. 13) On 4/28/23 at 1:00 AM, one pill (1) was documented as removed on the IPCDR from the bingo card by LPN #2 and was not reflected as administered on the eMAR. <p>Further review of the eMAR also revealed that the medication was documented as administered on 4/29/24, but was not documented as removed from the IPCDR, and included the following:</p> <p>On 4/29/24 at 1:55 AM, one pill (1) was signed on the eMAR but was not documented as removed on the IPCDR from the bingo card at that time.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A review of the IPCDR for Resident #12 reflected 13 doses were removed from the bingo card by 6 different nurses.</p> <p>On 4/30/24 at 9:40 AM, during an interview with two surveyors, the DON informed the surveyors that there was not a process in place prior to surveyor inquiry to ensure that the medication removed from the bingo card was in fact administered to the resident for whom the medication was prescribed for and was then documented on the eMAR.</p> <p>The surveyors discussed the concern regarding the discrepancy between the eMAR against the IPCDR, that resulted in 13 doses of a narcotic medication that was not accounted, and properly reconciled by 6 different nurses.</p> <p>On 4/30/23 at 11:17 AM, during a telephonic interview with the surveyors, the CCP stated that he conducted routine spot checks of the CSST and the IPCDR as part of the monthly visit for the facility.</p> <p>On 4/30/23 at 2:35 PM, during a telephonic interview with the survey team, LPN #1 confirmed worked on 4/9/24, 4/12/24, 4/17/24 and 4/22/24.</p> <p>At that time, the LPN stated that when it was time to administer the Oxycodone/APAP 5/325 mg to Resident #12, she opened the narcotic box within her cart, removed the medication, signed the IPCDR but at times she had a problem signing the eMAR on the laptop located on her medication cart because of technical computer issues.</p> <p>At that time, the LPN #1 admitted that she was able to sign the eMAR on the desktop computer located at the nurses' station but at times forgot. LPN #1 stated she had not informed the managers regarding the issues with the laptop on the medication cart.</p> <p>On 4/30/23 at 2:45 PM, the surveyor left a message for LPN #3.</p> <p>On 5/1/24 at 9:12 AM, during a meeting with the survey team, and the VPC, the DON stated that she had completed the investigation after surveyor inquiry regarding the 13 doses administered that were not signed on the eMAR by the 6 different nurses. The DON stated the following:</p> <ol style="list-style-type: none"> 1) LPN #1 who had worked on 4/9/24, 4/12/24, 4/17/24 and 4/22/24. The LPN#1 signed a statement that she had forgotten to sign the eMAR on the laptop due to a pop-up blocker. The DON had a signed statement from LPN #1. 2) LPN #2 worked on 4/8/24, 4/9/23, 4/12/24, 4/19/24, and 4/28/24. LPN #2 did not sign the eMAR because of the pop-up blocker on the laptop located on her medication cart and forgot to sign the eMAR on the desktop computer located at the nurses' station. LPN #2 confirmed she administered the medication on those days. The DON had a signed statement from LPN #2. 3) LPN #3 worked on 4/19/23 and administered the medication at 10:00 AM, that day. LPN #3 forgot to document the administration on the eMAR. The DON had a signed statement. 4) LPN #4 worked on 4/19/23 and administered the medication at 8:00 PM and admitted to not signing the eMAR. The DON had a signed statement. <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5) LPN #5 worked on 4/23/24 and administered the medication at 2:00 AM and forgot to sign the eMAR. The DON had a signed statement.</p> <p>6) LPN #6 worked on 4/26/24 and administered the medication at 8:20 PM and tried to sign the eMAR on the laptop but the signature did not go through. LPN #3 forgot to sign on the desktop located at the nurses' station.</p> <p>At that time, the VPC stated that the resident was assessed by the Nurse Practitioner and there was no change to the resident's PRN Oxycodone/APAP 5/325 since the resident was content with her pain medication regimen.</p> <p>At that time, the VPC stated that education was given to the nurses that reviewed the process for the shift-to shift count of narcotic medications, signing of the IPCDR and the eMAR to ensure no discrepancy occurred.</p> <p>At that time, the VPC stated that the technical support team, for the facility's laptop computer were informed of the issue.</p> <p>At that time, the DON stated that they had checked the laptop to ensure the technical issue was resolved.</p> <p>On 5/1/24 at 1:03 PM, during a meeting with the survey team, the LNHA, the AIT, the VPC, and the DON, the surveyors discussed the concern regarding the inaccurate reconciliation of narcotic medication of the IPDCP and the eMAR for Resident #12's Oxycodone/APAP 5/325 mg.</p> <p>3.) On 4/29/24 at 10:36 AM, the surveyor and LPN #7 began the Medication Room unit inspection of the refrigerator on the third floor.</p> <p>At 10:43 AM, in the presence of LPN #7, the surveyor observed a narcotic medication for Resident #80 with a pharmacy label of Lorazepam Intesol Oral Concentrate 2 mg/1 milliliter (ml). The Lorazepam Intesol 2 mg/1 ml bottle was sealed and dated 10/6/23.</p> <p>At that time, the surveyor and LPN #7 reviewed the electronic Medical Record (eMR) which reflected that Resident #80's Lorazepam Intesol 2 mg/1 ml was not part of the active orders for April 2024.</p> <p>Further review Resident #80's eMR revealed that the Lorazepam Intesol 2 mg/1 ml order was ultimately discontinued on 11/27/23, five (5) months before the surveyor's unit inspection.</p> <p>At that time, during an interview with the surveyor, LPN #7 stated that discontinued medication should have been removed from active inventory by the nurse and the unit manager should have been informed.</p> <p>LPN #2 stated it was important to remove discontinued medication from active inventory to prevent medication administration errors.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At 10:57 AM, during an interview with the surveyor, the Registered Nurse (RN)/ Unit Manager (UM) stated that the order for Resident #80 was a PRN (as needed order) that was automatically discontinued after 14 days. The RN/UM could not explain the process how the medication cart nurse could be aware that a narcotic medication was automatically discontinued while checking the negative inventory log.</p> <p>At 12:40 PM, during a meeting with the LPN/UM and the DON, the surveyor discussed the concerns regarding the discontinued Lorazepam for Resident #80 on the third floor that was still in with the active inventory.</p> <p>On 05/01/24 at 9:12 AM, during a meeting with the survey team and the DON, the VPC confirmed that the discontinued narcotic medication, Lorazepam should have been removed from the active inventory to prevent medication administration errors and drug diversion.</p> <p>On 5/01/24 at 1:03 PM, during a meeting with the survey team, the LNHA, the AIT, the VPC, and the DON, the surveyors discussed the concern regarding the failure to remove and dispose discontinued narcotic medication from active inventory after being discontinued on 11/27/23, five months before the medication storage inspection, for Resident #80.</p> <p>4.) On 4/29/24 at 11:34, the surveyor and LPN #1 began the narcotic medication inspection, which was stored in a mounted, double locked portion of the medication cart (narcotic box), located in the green side of the fourth floor.</p> <p>At that time, in the presence of LPN #1, the surveyor observed the CSST was signed daily until the day shift of April 29, 2024.</p> <p>At 11:42 AM, the surveyor and LPN #1 observed the safety tamper seal (provides visual evidence of any attempt to open or manipulate the packaged medication) was missing for Resident #8's Morphine Sulfate 20 mg/ml, dated 11/13/23. The content reflected 30 ml, and the IPCDR did not reflect when the medication was opened, why it was opened, or that an attempt to administer the medication had occurred. The reverse side of the IPCDR did not have a documentation that any dose was wasted.</p> <p>At that time, LPN #1 stated she did not break the seal for Resident #8's Morphine Sulfate 20 mg/ml.</p> <p>On 4/29/24 at 12:04 PM, during an interview with the surveyor the LPN/UM confirmed the patient safety tamper seal for the resident's Morphine should not have been missing since the medication was not documented as administered, refused, or damaged. The LPN/UM stated she was not sure of the facility policy, procedure, or process for when a safety tamper seal for the Morphine was accidentally removed.</p> <p>At 12:40 PM, during a meeting with the LPN/UM and the DON, the surveyor discussed the concerns regarding the unadministered Morphine for Resident #8 that had a missing safety tamper seal.</p> <p>On 4/30/23 at 9:40 AM, during a meeting with the surveyors and the ADON, the DON stated that when a medication was received from the pharmacy provider the narcotic medication was checked by the receiving nurse for integrity and accurate quantity. The DON was unable to identify when the safety tamper seal was missing.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>At that time, the DON stated she had given an in-service regarding the identification of a missing safety tamper seal.</p> <p>On 5/1/24 at 9:12 AM, during meeting with survey team and the DON, the VPC stated that during the shift-to shift count, once a safety tamper seal was identified as missing, the supervisor and the DON must be notified, medication removed, followed by the destruction/disposition of the medication. The DON and VPC stated that the maintenance of the safety tamper seal was important to avoid drug diversion and ensure the medication was not tampered with.</p> <p>On 5/1/24 at 1:03 PM, during a meeting with the survey team, the LNHA, the AIT, the VPC, and the DON, the surveyor discussed the concern for the received and stored narcotic medication was maintained with the safety tamper seal for Resident #8 and the failure to identify the concern during the shift to shift review.</p> <p>On 5/2/24 at 9:52 AM, during a meeting with the survey team, the LNHA, the AIT, the DON, the Rehabilitation Director, the VPC acknowledged the concerns.</p> <p>41858</p> <p>5.) The surveyor reviewed the electronic Medical Record (eMR) for Resident #212.</p> <p>According to the AR, Resident #212 was admitted to the facility with diagnoses which included but were not limited to: Type 2 Diabetes mellitus with Diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes causing pain or numbness) and Peripheral Vascular Disease, unspecified (a slow and progressive disorder of the blood vessels).</p> <p>A review of Resident #212's Admission MDS dated [DATE], revealed that the resident had a brief interview of mental status score of 10 of 15, which indicated the resident had a moderately impaired cognition. Further review of the MDS, revealed the resident was receiving an opioid medication.</p> <p>A review of the physician Order Summary Report revealed physician orders (PO) for Oxycodone-Acetaminophen Tablet 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for moderate to severe Pain (scale 4-10) -Order Date 04/17/24 1040 (10:40 AM).</p> <p>A review of the eMAR against the IPCDR log for Oxycodone/APAP 5/325 mg revealed that on 4/28/24 at 10:30 PM the Oxycodone/APAP 5/325 mg was removed from inventory, logged as removed on the IPCDR by LPN #8 however was not documented as administered on the eMAR for 4/28/2024 at 10:30 PM.</p> <p>On 4/30/24 at 3:45 PM, the above concern was presented to the VPC, who stated would investigate it.</p> <p>On 5/1/24 at 9:36 AM, during a meeting with the surveyors and the VPC, to review the facility's investigation for the above concern, the DON stated LPN #8 stated she signed the IPCDR but she forgot to sign the eMAR after she administered the medication to the resident.</p> <p>On 5/1/24 at 1:03 PM, during a meeting with the LNHA, the AIT, the VPC, and the DON, the surveyors discussed the concern regarding the inaccurate reconciliation of narcotic medication of the IPDCP and the eMAR for Resident #212's Oxycodone/APAP 5/325 mg.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/2/24 at 9:52 AM, during a follow up meeting with the survey team, the LNHA, the AIT, the DON, the Rehabilitation Director (RD), the VPC acknowledged the above concerns.</p> <p>37791</p> <p>6). On 4/22/24 at 11:04 AM, the surveyor observed Resident #148, who was seated in a wheelchair and was watching television. The resident was alert and oriented and was able to be interviewed. The surveyor interviewed the resident regarding his/her care at the facility and the resident had no complaints.</p> <p>The surveyor reviewed the medical record for Resident #148.</p> <p>A review of the resident's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and heart), hypertension (a condition in which the force of the blood against the artery walls is too high), and end stage renal disease (the final, permanent stage of chronic kidney disease).</p> <p>A review of the admission MDS dated of 1/30/2024, reflected the resident had a BIMS score of 13 out of 15, indicating that the resident was cognitively intact.</p> <p>A review of the April 2024 Order Summary Report (OSR) revealed a physician's order (PO) dated 2/15/24 for Midodrine Hydrochloride (HCL) 5 mg (milligrams) give 1 tablet by mouth three times a day for Hypotension (low blood pressure), hold for systolic blood pressure (SBP) (measures the pressure in your arteries when your heart beats) greater than 130.</p> <p>A review of the April 2024 eMAR revealed a PO dated 2/15/24 for Midodrine HCL 5 mg give 1 tablet by mouth three times a day for Hypotension, hold for SBP (systolic blood pressure, the top number of a blood pressure) greater than 130 with an administration time of 1000 (10:00 AM), 1400 (2:00 PM), and 2000 (8:00 PM). A further review of the eMAR revealed that the resident's medication administration times were adjusted on 4/3/24. At that time, the area to document the resident's blood pressure (BP) was x out in the EMAR. A further review of the eMAR revealed that the resident's BP was not documented in the eMAR from 10:00 AM of 4/3/24 until 10:00 AM on 4/24/24, after surveyor inquiry. Further review revealed there were 63 administration times in which the medication was administered when the BP was not documented.</p> <p>On 4/24/24 at 10:35 AM, in the presence of a Registered Nurse (RN) #1, the surveyor reviewed the resident's Pos. RN#1 acknowledged that the resident had an order for Midodrine with a perimeter to hold the medication when the resident SBP was above 130. At that time, review of the eMAR revealed the resident's BP was not being documented under Midodrine. The RN stated that the BP should have been recorded every time that Midodrine was administered. In the presence of the surveyor, RN #1 adjusted the eMAR documentation that would allow the BP to be recorded. The RN was unable to answer why the EMAR was not adjusted earlier.</p> <p>On 5/1/24 at 1:00 PM, the surveyor presented the above concern to the administration team which included the LNHA, the AIT, the DON, and the [NAME] President of Clinical Services (VPC).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 5/2/24 at 11:30 AM, as part of the facility response, the VPC stated that when the resident's medication times were adjusted for dialysis purposes and the nurse should have documented in the eMAR that the resident's vitals had to be recorded, this would have allowed for nurses to document the resident's BP. She acknowledged that this was not done when the medication times were adjusted.</p> <p>7). On 4/30/24 at 9:00 AM, during morning medication pass, the surveyor observed a Licensed Practical Nurse (LPN# 9) preparing medications for Resident #52. The surveyor observed LPN #9 open the medication cart, unlock the narcotic lock box and pull out a bingo card Pregabalin (Lyrica) 50 mg capsules. The bingo card contained twenty (20) capsules of Pregabalin. The surveyor observed LPN #7 look at the resident's eMAR and she stated that the resident is on Pregabalin 100 mg. She then investigated the medication cart narcotic lock box and found a bingo card for Lyrica 100 mg that contained six (6) capsules. At that time, LPN#? stated that after she finished medication pass, she was going to investigate to see if the resident was still being administered Pregabalin 50 mg.</p> <p>On 4/30/24 at 9:30 AM, during medication pass reconciliation the surveyor reviewed Resident #52's physician's orders which revealed that the resident's Pregabalin 50 mg capsules were discontinued on 4/26/24.</p> <p>The surveyor reviewed the medication record for Resident #52.</p> <p>A review of the resident's AR revealed the resident was admitted to the facility with diagnoses which included but were not limited to: chronic obstructive pulmonary disease(a type of lung disease that block airflow and makes it difficult to breathe), atrial fibrillation (irregular, often rapid heart rate that commonly causes poor blood flow), unspecified pain (a disorder characterized by sensation of marked discomfort, distress and agony), and diabetes mellitus (is a disorder in which the amount of sugar in the blood is elevated).</p> <p>A review of the admission MDS dated [DATE], reflected the resident had a BIMS score of 13 out of 15, indicating that the resident was cognitively intact.</p> <p>A review of the April 2024 OSR revealed a PO dated 4/30/24 for Pregabalin oral capsule 100 mg give 1 capsule by mouth two times a day for Neuropathic (relating to the nerve) pain. The April 2024 OSR report also showed that the resident had the following discontinued PO's: Pregabalin oral capsule 50 mg give 1 capsule by mouth two times a day for neuropathy which had a start date of 4/4/24 and a discontinued date of 4/26/24. The resident also had a discontinued PO for Pregabalin oral capsule 75 mg give 1 capsule by mouth two times daily for neuropathy for three days with a start date of 4/26/24 and a discontinued date of 4/29/24.</p> <p>On 4/30/24 at 9:40 AM, the surveyor interviewed LPN #9 who acknowledge that the resident's Pregabalin 50 mg was discontinued and should have been removed from the medication cart immediately. She stated that by leaving a discontinued medication with active medication could have led to a medication error or drug diversion. She stated that she gave the discontinued Pregabalin to her supervisor and that she was destroying the medication with another nurse.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 4/30/24 at 9:45 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who acknowledge that both Pregabalin 50 mg (20 capsules) and Pregabalin 75 mg (1 capsule) were both discontinued and should have been removed from the medication cart after being discontinued. She further stated that leaving discontinued medication with active medication could have the potential to cause a medication error or diversion. The RN/UM made the surveyor a copy of the IPCDR form which showed that both Pregabalin 50 mg (20 capsules) and Pregabalin 75 mg (1 capsule) were destroyed in the presence of two nurses.</p> <p>On 5/1/24 at 1:00 PM, the surveyor discussed the above concern with the facility administration team which included the LNHA, the AIT, the DON, and the VPC.</p> <p>No further information was provided.</p> <p>A review of the undated facility policy provided, Controlled Substance Administration and Accountability included the following:</p> <p>Policy: It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion, or accidental exposure.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. General Protocols:</p> <p>Section F, subsection ii. All controlled substance obtained from non-automated medication cart or cabinet are recorded on designated usage form. Written documentation must be clearly legible with all applicable information provided.</p> <p>Section I.</p> <p>The Controlled Drug record is a permanent medical record document and in conjunction with the MAR is the source for documenting any specific narcotic dispensed from the pharmacy.</p> <p>3. Obtaining/Removing/Destroying Medications</p> <p>a. The entire amount of controlled substance obtained or dispensed is accounted for.</p> <p>Discrepancy Resolution</p> <p>a. Any discrepancy in the count of controlled substance or disposition of the narcotic keys is resolved by the end of the shift during which it is discovered.</p> <p>j. The charge nurse or other designee conducts a random visual audit of the required documentation of controlled substances. Spot checks are performed to verify:</p> <p>i. Controlled substances that are destroyed appropriately documented; and</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>ii. Medications removed from either the automated dispensing system or medication cart/cabinet have a documented physician order.</p> <p>A review of the undated facility policy, Controll [TRUNCATED]</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>41858</p> <p>Refer to F 755</p> <p>Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that a resident received as needed (prn) narcotic (a controlled drug that produces pain relief) medication in accordance with the prescriber's orders and accepted professional standards. The deficient practice was identified for 1 of 5 residents (Resident #212) reviewed for prn narcotic administration.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 04/30/24 at 10:35 AM, the surveyors requested a list of all residents receiving the prn narcotic oxycodone 5/325 mg (milligrams) from Director of Nursing (DON).</p> <p>On 04/30/24 at 11:20 AM, the DON provided the surveyors with a list of the residents receiving prn Oxycodone-Acetaminophen (an opioid (pain-relieving medicines, narcotic) combination medication used for moderate to severe pain.). A review of the list revealed Resident #212 was receiving the above-mentioned medication.</p> <p>The surveyor reviewed the electronic Medical Record (eMR) for Resident #212.</p> <p>According to the Admission Record, Resident #212 was admitted to the facility with diagnoses which included but were not limited to: Type 2 Diabetes mellitus with Diabetic polyneuropathy (a type of nerve damage that can occur if you have diabetes causing pain or numbness) and Peripheral Vascular Disease, unspecified (a slow and progressive disorder of the blood vessels).</p> <p>A review of Resident #212's Admission Minimum Data Set (MDS), an assessment tool dated 04/11/24, revealed that the resident had a brief interview of mental status score of 10 of 15, which indicated the resident had a moderately impaired cognition. Further review of the MDS, revealed the resident was receiving an opioid medication.</p> <p>A review of the resident's care plan revealed a Focus: [name redacted] has Potential for pain r/t Disease Process. Date Initiated: 04/04/2024. Interventions: . Assess my medications and adjust as needed Date Initiated: 04/04/2024 .Monitor for pain every shift, Date Initiated: 04/04/2024 .Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Date Initiated: 04/04/2024.</p> <p>A review of the physician Order Summary Report revealed physician orders (PO) for Oxycodone-Acetaminophen Tablet 10- 325 MG, Give 1 tablet by mouth every 12 hours as needed for Pain -Order Date 04/07/2024 2300 (11:00 PM) -D/C (discontinued) Date 04/16/2024 2048 (8:48 PM) and Oxycodone-Acetaminophen Tablet 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for moderate to severe Pain (scale 4-10) -Order Date 04/17/2024 1040 (10:40 AM).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of Resident #212's Oxycodone/APAP (Acetaminophen) 5-325 mg Tablet Individual Patient Controlled Drug Record ((IPCDR), a declining inventory sheet signed by the nurse to account for Narcotic tablets being removed from the medication cart) Date received 4/18/24, amount received 30 (tablets) revealed the following tablet removal entrees:</p> <p>-4/20/24 at 10 AM, no other tablets were signed as removed for this date.</p> <p>-4/21/24 no tablets were signed as being removed</p> <p>-4/22/24 no tablets were signed as being removed</p> <p>-4/25/24 at 4 PM and 9 PM</p> <p>A review of the April 2024 electronic Medication Administration Record (eMAR) (used by the nurse to account for the medication being administered to the resident) for Oxycodone-Acetaminophen Tablet 5-325 MG, Give 1 tablet by mouth every 6 hours as needed for moderate to severe Pain (scale 4-10) -Order Date 04/17/2024 1040 (10:40 AM) revealed the tablets were signed as being as administered as following:</p> <p>-4/20/24 at 0841(8:41 AM) and 1802 (6:02 PM)</p> <p>-4/21/24 at 0032 (12:32 AM), 1516 (3:16 PM) and 1800 (6:00 PM)</p> <p>-4/22/24 at 1958 (7:58 PM)</p> <p>-4/25/24 at 0815 (8:15 AM), 1557 (3:57 AM), and 22:03 (10:03 PM)</p> <p>On 04/30/24 at 3:45 PM, the surveyor presented the above-mentioned discrepancies to the [NAME] President of Clinical (VPC). The VPC stated a full investigation would be completed.</p> <p>A review of the facility provided investigation for the above investigation completed by the Unit Manager/RN revealed the following:</p> <p>On 04/20/24, in the eMAR it was documented that it was given at 8:41 AM and 18:02 pm. As per the declining sheet (IPCDR), it was noted that it (Oxycodone-Acetaminophen 5/325 mg) was given at 10 am by [name redacted] (RN#2). The 18:02 pm dose was given by Licensed Practical Nurse (LPN) #1. Oxycodone-Acetaminophen 10/325 mg was given instead of Oxycodone-Acetaminophen 5/325 mg.</p> <p>On 04/21/24, in the eMAR documentation, medication was administered at 12:32 am, 15:16 pm, and 1800 pm. It can be found on the declining sheet for Oxycodone-Acetaminophen 10/325 mg was given instead of Oxycodone-Acetaminophen 5/325 mg and was signed at 12:32 am, 12 pm, and 6 pm by [name redacted] (LPN #1), [name redacted] (LPN #2), and [name redacted] (LPN#3).</p> <p>On 04/22/24, it was documented in the eMAR at 19:58 pm in the declining sheet for Oxycodone-Acetaminophen 10/325 mg instead of Oxycodone-Acetaminophen 5/325 mg was documented that it was administered at 8 pm by [name redacted] (LPN #4).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 04/25/24, in the eMAR it was documented that medication was administered at 8:15 am. Documentation in the declining sheet can be found in Oxycodone-Acetaminophen 10/325 mg by [name redacted] (LPN#4).</p> <p>On 05/01/24 at 9:36 AM, the DON and VPC reviewed the results of the above-mentioned investigation with the surveyors. The DON stated they compared the days and time documented in the eMAR and upon investigation, We found that there was a medication error. She further stated there was an initial order for Oxycodone 10-325 mg that was discontinued, and Registered Nurse (RN) #1 confirmed the new order for Oxycodone 5-325 mg. The DON stated that when the Oxycodone 10-325 mg order was discontinued and the bingo card (a bubble packaging used for medication) for the Oxycodone 10-325 mg tablets should have been removed from the narcotic drawer. The DON confirmed that the Oxycodone 10/325 bingo card and the 5/325 mg bingo cards were both in the narcotic drawer. The DON then stated, [name redacted] (RN#1) did not remove the 10-325 bingo card and the 5-325 mg bingo card was added and the nurses were administering the wrong dose. The DON further stated they (the nurses) did not follow the 5 rights of medication administration: right resident, right medication, right dosage, right route and right time. She then confirmed 4 different nurses gave the wrong dose 6 times.</p> <p>A review of the facility provided Medication Pass Observations Worksheet (a sheet used to evaluate a nurse during medication administration) revealed that the observations were completed as follows:</p> <p>-On 07/13/23 at 8 AM, RN# 2 received a check under the yes column for 9. Medication Administration: a. Medications removed from container properly, b. Label x 3 .f. Medications administered at correct time .h. correct dose administered.</p> <p>-On 03/29/24 at 8:00 AM, LPN #1 received a check under the yes column for 9. Medication Administration: a. Medications removed from container properly, b. Label x 3 .f. Medications administered at correct time .h. correct dose administered.</p> <p>-On 03/7/24 at 8:00 AM, LPN #2 received a check under the yes column for 9. Medication Administration: a. Medications removed from container properly, b. Label x 3 .e. If necessary, Controlled Substance Log signed f. Medications administered at correct time .h. correct dose administered.</p> <p>-On 11/13/23 at 9:00 AM, LPN #3 received a check under the yes column for 9. Medication Administration: a. Medications removed from container properly, b. Label x 3 .f. Medications administered at correct time .h. correct dose administered.</p> <p>-On 03/29/24 at 8:00 AM, LPN #4 received a check under the yes column for 9. Medication Administration: a. Medications removed from container properly, b. Label x 3 .f. Medications administered at correct time .h. correct dose administered.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of the facility policy Medication Errors dated 1/1/2022, revealed Policy: It is the policy of this facility to provide protections for the health, welfare, rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Policy Explanation and Compliance Guidelines: 1. The facility shall ensure medications will be administered as follows: a. according to physician's orders .c. In accordance with accepted standards and principles which apply to professionals providing services .4. The facility will consider factors indicating errors in medication administration, including, but not limited to, the following: a. Medication administered not in accordance with the prescriber's order. Examples include, but not limited to: i. incorrect dose, route of administration, dosage form, time of administration; ii. medication omission; iii. incorrect medication .c. Medication administered not in accordance with professional standards and principles .7. To prevent medication errors and ensure safe medication administration, nurses should verify the following information: a. Right medications, dose, route and time of administration; b. right resident and right documentation.</p> <p>N.J.A.C.: 8.39-29.2 (d)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45208</p> <p>Based on observation, interview and review of documentation provided by the facility, it was determined that the facility failed to a) maintain proper kitchen sanitation practices and clean equipment, b) properly store foods in a safe manner to prevent the development of food borne illness, c) maintain 4 of 4 nursing unit kitchenettes used for residents in a sanitary manner, and d) properly dispose of used cooking oil according to regulations. These deficient practices observed as evidenced by the following:</p> <p>On 04/22/24 at 09:42 AM, in the presence of the Food Service Director (FSD) and the food service manager (FSM), the surveyor toured the kitchen and observed the following:</p> <ol style="list-style-type: none"> 1. In the walk-in freezer, the surveyor observed several boxes of opened food items that were opened, unlabeled and exposed to freezer with freezer burn and frost on them. Those items were as follows: fish fillets, breaded chicken patties, turkey burgers, Salisbury beef steaks, opened loose corn, and tater tots. All listed items were opened, unsealed, unlabeled with open date or expiration dates. The FSM manager was unable to say when the packages were opened. 2. The cooktop food catch tray had hard, thick, flakey black sediment on the pan along with visible food debris that were burnt. The FSD and DM acknowledged that it needed to be thoroughly cleaned. The FSD also stated, it did not meet his expectations of his staff. 3. The fryer oil was heavily laden with sediment that was floating on the surface. There was a thick rim of sediment on the edges of the oil and the fryer wall. The FSD and DM acknowledged that it needed to be thoroughly drained and is supposed to be drained, cleaned and replaced weekly. The FSD also stated, he was unsure of the last time it was drained or cleaned. But they do not use it regularly. Surveyor asked if he would want to eat food that was fried in that oil? The FSD stated, no, it is unsanitary. 4. The fryer oil cleaning, disposal draining and schedule: the surveyor observed a heavily sedimented dark colored oil in the fryer with a lot of debris floating on top and caked around the rim and sides of the fryer oil. The FSD was unable to provide an oil disposal policy or oil disposal pickup invoices for the last 12 months. <p>On 4/25/24 at 12:08 PM the surveyor observed 4 of 4 kitchenettes, one on each nursing unit. The purpose of the kitchenette was for residential use. Each kitchenette was equipped with a refrigerator, microwave, sink and ice machine/water dispenser. The surveyor observed the following:</p> <ol style="list-style-type: none"> 5. The kitchenette refrigerator/freezer units to be filled with debris in the gaskets around the door of the refrigerator and freezer on the 2nd floor unit, the NA unit, the 3rd floor unit, and the 4th floor unit. 6. The kitchenette freezer unit on the 3rd floor nursing unit had a build-up of icicles on the interior door. The gasket on the top of the freezer top was visibly torn and cracked. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>7. The 4th floor unit kitchenette:</p> <ul style="list-style-type: none"> - the microwave with heavily crusted sediment in different colors on the inside of the microwave. -there was a lot of debris on the counter, under and around the microwave of crumbs, colored flakes, and substances of unknown origin. -there was a black discolored sediment behind the sink in the kitchenette where the backsplash and counter met for the length of the sink. <p>8. The kitchenette ice machine/water dispenser on 4 of 4 nursing units (2nd floor unit, the NA unit, the 3rd floor unit, and the 4th floor) to be visibly dirty with white sediment heavily around the internal and external rim of each dispensing shoot for ice and water.</p> <p>9. The kitchenette ice machine/water dispenser on 2 of 4 nursing units (NA unit and the 3rd floor unit) to be visibly dirty with brown sediment in the interior of the ice and water dispenser shoot.</p> <p>On 04/22/24 at 10:15 AM, the surveyor interviewed the FSD who stated, that labeling of food is a requirement in his kitchen. The food should be labeled with expiration date and if opened it should be labeled with open date and the package should be resealed to keep the contents fresh. Labeling allows for first in first out concept which saves food integrity, prevents freezer burn, and waste production. He further stated, The cooking equipment is on a cleaning schedule and the findings of the kitchen equipment (fryer, catch tray, side of oven and griddle) should have all been cleaned. Cleaning is to prevent illness, cross contamination, pest, and rodents. We do not use the fryer that often but it should be changed monthly. He further stated, that proper cleaning of the catch tray is to prevent flare fires, hazardous food preparation causing bacteria and can attract pests. It should be cleaned daily after use and preparation of meals.</p> <p>On 04/25/24 at 09:47AM, the surveyor interviewed the FSD for the process of cooking oil disposal. The FSD stated, we put in the container and the oil guy picks it up. We might have not used it this month, we change it monthly. The surveyor requested 12 months of records for fryer oil disposal (approx. 8 gallons each use). The FSD was unable to provide documentation citing that maintenance disposed of it.</p> <p>On 04/25/24 at 09:55 AM, the surveyor interviewed the head chef who stated, the staff drains the oil back into the containers the oil came in. Then I notify the maintenance department to call the guy that picks it up for disposal. I do not have any accountability logs on when it was picked up or disposal done monthly.</p> <p>On 04/25/24 at 10:03 AM, the surveyor interviewed the maintenance director, who stated, I am responsible for the building, but I have only been here a year. I have never called a company to come pick up frying oil and we do not have a collection container on site to my knowledge. I am unaware of any contracted company for oil pick up with this facility.</p> <p>On 04/25/24 at 10:18 AM, the surveyor interviewed the [NAME] President of Clinical (VPC) who stated, there is not a process or policy available for the fryer and its contents at this time. We contract a company that runs the facility kitchen. I must call for the policy. We do not have anything to provide.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/25/24 at 12:21 PM, the surveyor interviewed the registered nurse unit manager (RNUM) for the 3rd floor nursing unit, who stated, I acknowledge the ice buildup on the freezer door, the debris on the gaskets of the refrigerator and freezer. I also acknowledge the white and brown sediment on the ice/water dispenser shoots. The staff is supposed to alert me to any issues, and I will direct the concern to the appropriate department. We also have a maintenance log that has a copy receipt system for the maintenance department to acknowledge and respond to the concern.</p> <p>On 04/25/24 at 12:34 PM, the surveyor interviewed the licensed practical nurse unit manager, (LPNUM) on the 4th floor, who stated, I acknowledge the debris on the gaskets of the refrigerator and freezer. I see and acknowledge the black sediment behind the sink on counter and the wall. I see and acknowledge the debris and stuck on sediment on the interior of the microwave. It all should be reported to me and cleaned by housekeeping. It can cause illness and attract rodents and pests.</p> <p>On 04/25/24 at 12:48 PM, the surveyor interviewed the Infection Preventionist (IP) who stated, the reason to have a clean and unsoiled kitchenette is to prevent pest, rodents, and bacteria. It should be maintained and clean for the residents because this is their home.</p> <p>On 04/25/24 at 12:51 PM, the surveyor conducted an interview with the Maintenance Director and the Director of Operations (DOO). The DOO stated, the facility is contracted with an outside company that comes in to descale the ice machines on the units bi-annually (2 times a year). External cleaning is done by the housekeeping department. If there is a reported issue, we can descale more often. The Maintenance Director stated, I was unaware of any issues. There were not any reported to my department or on the maintenance log.</p> <p>On 04/25/24 at 01:07 PM, the surveyor interviewed the housekeeping director (HD), who stated, the kitchenettes are scheduled weekly. He stated that the cleaning consists of disinfecting and wiping down the refrigerator inside and out, wiping the interior and exterior of the microwave, and cleaning the counters. He further stated, the facility has a floor steward who does the mopping on each unit. The HD stated, if there are any noticeable issues that cannot be cleaned correctly, my staff is to report it to me and I will forward to the correct department. The HD further stated, The rationale for this cleaning schedule for the kitchenette is because the resident's food gets stored in the refrigerator and gets warmed up in the microwave. It can cause cross contamination issues and bacterial microorganisms. For aesthetics it is to prevent and create a safe and clean environment for staff and visitors. It is also to prevent rodents and pest.</p> <p>On 04/29/24 at 12:02 PM, the surveyor met with the maintenance director and the licensed nursing home administrator (LNHA), who provided a filter log for the ice machines and water dispenser. A review of the logs revealed that the filters were being changed 2 times a month. The surveyor asked if the filter provided descaling and disinfection of the ice/water dispenser? They both stated, it did not clean, disinfect, or descale the unit.</p> <p>The surveyor reviewed an undated job description of Cook, job code R-7 (35 hours), which revealed:</p> <p>Essential job function:</p> <p>~maintains food storage area and kitchen in a clean and sanitary manor.</p> <p>~stores food and defrosts meats according to prescribed sanitation techniques.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The surveyor reviewed HCSG policy 027, Equipment, dated original 5/2014, revised 9/2017, which revealed:</p> <p>3. All food contact equipment will be cleaned and sanitized after every use.</p> <p>4. All non-food contact equipment will be cleaned and free of debris.</p> <p>The surveyor reviewed 'HCSG policy 019, Food storage: cold foods, dated original 5/2014, Revised 2/2023, which revealed:</p> <p>Policy statement:</p> <p>all time/temperature control for safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA food code.</p> <p>Procedures:</p> <p>5. All foods will be stored wrapped or in a covered container, labeled, dated, and arranged in a manner to prevent contamination.</p> <p>The surveyor reviewed the undated, routine cleaning and disinfection policy which revealed:</p> <p>Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.</p> <p>Definitions:</p> <p>Cleaning- refers to the removal of visible soil form objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products.</p> <p>Disinfection- refers to thermal or chemical destruction of pathogenic and other types of microorganisms.</p> <p>Policy explanation and compliance guidelines:</p> <p>4. Routine surface cleaning and disinfection will be conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to; j. sink and faucets.</p> <p>12. Horizontal surfaces with frequent hand contact in routine resident care areas should be cleaned: a) on a regular basis, b) when soiling and spills occur.</p> <p>The surveyor reviewed an undated Refrigerator policy which revealed Policy Statement: Refrigerators will be monitored following these guidelines to ensure the avoidance of practices that could result in foodborne illness.</p> <p>Cleaning: Refrigerators are cleaned weekly by housekeeping.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The surveyor reviewed an undated Ice machine policy, which revealed, it is the policy of this facility to ensure that the ice machines/carts are working in proper order, cleaned, and maintained as per Federal, State, local, or facility guidance, according to manufactures instructions and current standards of practice.</p> <p>The surveyor reviewed Emergency water management policy updated 11/7/23. which revealed section Control Measures & Corrective Actions:</p> <p>1)Ice Machines: The ice machine is cleaned and disinfected quarterly.</p> <p>4) Water Coolers: The water cooler is cleaned and disinfected quarterly.</p> <p>Reference: P.L. 2020, c.24 (N.J.S.A. 13:1E-99.122) requires large food waste generators who generate an average projected volume of 52 tons of food waste or more per year to source separate and recycle their food waste. Large food waste generators must comply with the Law if they are located within 25 road miles of an authorized food waste recycling facility, generates a projected average of 52 tons or more of food waste per year, and fit into one of the following categories: commercial food wholesaler, distributor, industrial food processor, supermarket, resort, conference center, banquet hall, restaurant, educational or religious institution, military installation, prison, hospital, medical facility, or casino.</p> <p>Food waste is defined as: Food processing vegetative waste, food processing residue generated from processing and packaging operations, overripe produce, trimmings from food, food product over-runs from food processing, soiled and unrecyclable paper generated from food processing, and used cooking fats, oil, and grease. Plate waste and food donated by the establishment is not considered food waste and shall not be included when estimating or measuring the amount of food waste generated.</p> <p>NJAC 8:39-17.2(g)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>39885</p> <p>Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to ensure that the documented coordination/communication was consistent and was provided between facility staff and hospice staff for one (1) of three (3) residents reviewed for hospice and end of life (Resident #93).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 4/29/24 at 11:51 AM, the surveyor observed Resident #93 asleep in their bed.</p> <p>The surveyor reviewed the medical records of Resident #93.</p> <p>Resident # 93's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors) and heart failure (a chronic condition in which the heart doesn't pump blood as well as it should).</p> <p>A review of Resident #93's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 02/09/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated that Resident #93's cognition was severely impaired. Further review of the MDS indicated Resident #93 received hospice services.</p> <p>On 4/29/24 at 11:53 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The LPN stated that Resident #93 was previously on hospice services but that the resident was discharged from hospice services on Friday (4/26/24). She added that the nurse visited one time a week when the resident was on hospice services. The LPN stated that there was a binder at the nurse's station that had documentation from the hospice staff. She added that the hospice nurse would verbally tell her if there were any recommendations.</p> <p>A review of Resident #93's hospice provider binder included a hospice summary note dated 01/29/24 by the hospice nurse. There were no subsequent summary notes written by a nurse in the binder. A review of the hybrid medical record indicated that there were two hospice summary notes dated 02/21/24 and 3/18/24 written by the Social Worker. There were no weekly hospice summary notes written by the nurse in the hybrid medical record.</p> <p>On 4/29/24 at 12:12 PM, the surveyor asked the LPN the reason there were no subsequent nurse visit documentation after 01/29/24. The LPN stated that she could not answer why there were no other nurse visit summary notes. She added that Resident #93 did not have any new changes in the last few months.</p> <p>On 4/29/24 at 12:26 PM, the surveyor interviewed the Director of Social Services (DSS). The DSS stated that Resident #93 had been on hospice services since May 2023 until 4/26/24 when the resident was discharged from hospice services. She added that the hospice provider told her verbally that Resident #93 was coming off hospice.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility provided Physician Order Report included an order to Admit to [name redacted] hospice DX (diagnosis): Aspiration PN (pneumonia) Respiratory Failure with Hypoxia with an order date of 5/03/23 and a discontinued date of 4/28/24.</p> <p>On 4/30/24 at 10:13 AM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) for the second floor unit. The UM/RN stated that she did not currently have any residents on hospice services. She added that Resident #93 had been on hospice services but was discharged from the services because the resident improved and did not meet the criteria any longer. The UM/RN stated that hospice nurse would visit one time a week and that they could call the nurse if the resident needed additional visits. The UM/RN stated that the hospice provider had their own binder and that if there were any changes then the nurse would communicate with us.</p> <p>At that same time, the LPN and UM/RN confirmed that Resident #93 did not have any hospice summary notes by a nurse after the 01/29/24 visit. The UM/RN stated that the hospice nurse called the facility Social Worker to let her know the resident was being discharged from services on Friday night (4/26/24). She added that the Social Worker informed me and that she contacted the primary physician and discontinued the order.</p> <p>A review of Resident #93's Progress Notes included the following notes:</p> <p>4/29/2024 12:30 General Note: Effective 4/26/24 mid(midnight) res (resident) no longer on hospice care, over-all condition improved, Social worker/family/NP (Nurse Practitioner) [name redacted] made aware.</p> <p>4/29/2024 13:31 Social Service Note: SW placed a call to resident's brother [name redacted] to clarify residents' code status. Resident recently discharged from Hospice as of 4/26/24 midnight. Responsible party wishes for resident to be a full code. POA (Power of Attorney) Healthcare documentation uploaded into [name redacted]. Order and care plan updated. No other issues. Team notified.</p> <p>The two above Progress Notes were written after surveyor inquiry on 4/29/24 at 11:53 AM.</p> <p>Further review of Resident #93's Progress Notes included a care plan note dated 02/28/24 which included the following: Quarterly note: Team met .Currently on Hospice care with [name redacted] hospice daily; comfort care and pain management in place and was effective. Plan of care reviewed and ongoing. Family very involved and supportive of his/her care The note listed the facility staff that attended the meeting and Resident #93's responsible party via phone.</p> <p>There was no documentation that a representative of Resident #93's hospice provider attended the meeting.</p> <p>There were no weekly notes by the facility nurses to document any verbal discussions with the hospice nurse.</p> <p>On 5/01/24 at 8:24 AM, the surveyor interviewed the Director of Nursing (DON) regarding hospice services. The DON stated that if a resident qualifies for hospice services then a resident will be admitted to the hospice services a hospice nurse visits two to three times a week. The DON stated that the hospice nurse would talk to the facility nurse and sometimes they document in the medical record. She added that if there is a recommendation then the nurse would document in the Progress Notes.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On that same date and time, the DON stated that hospice staff attend the quarterly care plan meeting. The DON stated that there would be a communication form when the hospice services was terminated. The surveyor notified the DON the concern that there was documentation from the nurses and no documentation of the termination in Resident #93's medical record. The DON stated that she would have to find out if it was done verbally. She then added if it was done verbally then it should have been documented by the nurse. The surveyor asked if there should be documentation regarding the visits. The DON stated that quarterly was fine. She added that if there were no changes or recommendations then they don't sign.</p> <p>On 5/01/24 at 9:25 AM, the surveyor interviewed Resident #93's hospice provider's Clinical Director of Central Region/Registered Nurse (CD/RN), via telephone, regarding the process for hospice services. The CD/RN stated that a Registered Nurse alternated with a Licensed Practical Nurse and visited the resident at least one time per week and that the frequency would increase if needed for wounds or end of life. She added that if the facility had a meeting and we were invited then we would send someone to represent. The CD/RN stated that each resident on hospice services had a binder which included the certification for services, medicine profile, plan of care and a hospice summary note that is filled out by the nurse at each visit.</p> <p>She added that her nurse would also document in the hospice's electronic medical record and that would include who the nurse spoke with at the facility. The surveyor then asked why there was no documentation of any visits by a nurse since 01/29/24 for Resident #93. The CD/RN stated that she did not know why the binder did not have the visits but that there should have been sheets in the binder. She added that Resident #93 had weekly visits by the nurse and communication with the facility's nurses. The CD/RN stated that discharge paperwork should be in the binder or the medical chart.</p> <p>On 5/01/2024 at 12:09 PM, the surveyor received an email from Resident #93's hospice provider's CD/RN which included the following:</p> <p>The RN had the communication forms with her. I reminded her to leave a copy in the facility binder.</p> <p>The email also included the documentation of the weekly visits.</p> <p>On 5/01/24 at 01:05 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Administrator in Training (AIT), DON and VP of Clinical (VPoC) the concern that Resident #93 did not have documentation for any nursing visits from hospice since 01/29/24, there was no documentation regarding the discontinuation of hospice services and that a representative from hospice was not part of the care plan meeting on 02/28/24.</p> <p>On 5/02/24 at 9:52 AM, in the presence of the survey team, LNHA, DON, AIT and Director of Rehab, the VPoC stated that Resident #93 was discharged from hospice and that the Social Worker received an email notification on 4/24/24 that the resident was being discharged from hospice on 4/26/24. The surveyor asked if the communication should have been in the medical record. The VPoC stated yes.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Furthermore, the VPoC stated that when the resident was started on hospice, the hospice representative was included in the meeting but that there was a change and the new person that started did not respond regarding the care plan meeting. The VPoC further stated that the care plan meeting had acknowledgement from facility staff that the resident was receiving hospice services but that there was no documentation of hospice staff being present. The VPoC also stated that they did not have the weekly visits documented in the medical record and that they should have been documented.</p> <p>The facility did not provide any additional information.</p> <p>A review of the facility provided written agreement between Resident #93's hospice provider and the facility included the following:</p> <p>Article 5 Mutual Responsibilities & Coordination of Services</p> <p>5.1 Manner of Communication. To ensure the needs of the patients are met twenty-four (24) hours a day, HOSPICE and FACILITY shall communicate orally with each other, in person or by telephone, as needed, and document such communication in the applicable Residential Hospice Patient's chart and via facsimile, email, or first class mail.</p> <p>A review of the facility provided policy titled, Hospice Program with an updated date of 1/2023, included the following:</p> <p>10. In general, it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. These include: .</p> <p>d. Communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day; .</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327</p> <p>Based on observation, interview, and review of the facility provided documents, it was determined that the facility failed to ensure: a) the staff handled, stored, and processed linens and other supplies in a clean manner and to prevent possible contamination for two (2) of two (2) rooms (Laundry and Linen Storage) according to facility's policy and Centers for Disease Control and Prevention (CDC) guidelines, b) routine, ongoing, and systematic monitoring and tracking of facility's water management, and c) policy was reviewed and updated to reflect and address the need of the facility according to clinical standard of practice and CDC guidelines, d) maintain the resident's Tube Feed hydration bag with proper infection control practices for one (1) of five (5) residents reviewed for Tube Feeding, and e) a urinary catheter drainage bag and a urinary catheter tubing were maintained and stored in a manner to prevent the spread of infection for one (1) of two (2) residents reviewed for urinary catheter and urinary tract infections (UTIs), Resident # 105.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the CDC, Appendix D - Linen and laundry management, last reviewed May 4, 2023, Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens.</p> <p>According to the CDC, What Owners and Managers of Buildings and Healthcare Facilities Need to Know about Legionella Water Management Programs, Page last reviewed: April 30, 2018, included, How to Develop a Legionella Water Management Program</p> <p>Developing and maintaining a water management program is a multi-step process that requires continuous review. Below are steps to building an effective Legionella water management program:</p> <ul style="list-style-type: none"> -Establish a water management program team -Identify areas where Legionella could grow and spread <p>Identify where potentially hazardous conditions could occur in your building water systems, such as areas where water temperature could promote Legionella growth or where water flow might be low.</p> <ul style="list-style-type: none"> -Decide where you need to apply control measures and how to monitor them -Make sure the program is running as designed and is effective <p>Establish procedures, both initially and on an ongoing basis, to verify that your team is implementing the water management program as designed.</p> <ul style="list-style-type: none"> -Document and communicate all activities on a continual basis. <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1. On 4/25/24 at 11:41 AM, the surveyor toured the Laundry area in the presence of the Director of Housekeeping (DH). The DH informed the surveyor that the facility's laundry was being outsourced (obtain (goods or a service) from an outside). He also stated that the things being laundered at the facility were the tablecloths, curtains, and some residents' clothing in case of emergency.</p> <p>On that same date and time, the surveyor in the presence of the DH observed in the Laundry Room the following:</p> <p>The inside part of the washer had white dried substances. The DH stated that was from the residue of chemicals used in laundry. The surveyor asked the DH how often the washer was being cleaned or should be cleaned. The DH stated that it was not being cleaned.</p> <p>There were towels (big and small) folded on top of table with paper near the puncher, and a stapler. The DH stated that those towels were considered clean. The surveyor asked if those towels were clean, why it was exposed to the environment (not properly stored), and the DH had no answer.</p> <p>Later on, the DH asked the surveyor Where do you want me to put the towels? He further stated that there was not enough place in the laundry room which was why the clean towels were placed next to the working supplies.</p> <p>The long table where there was an equipment for naming clothes had dried whitish color and blackish substances and there was a file of clothes. The DH considered the residents clothes clean and waiting to be tagged with residents' names. The surveyor asked if that should be stored or kept in a bag and the DH had no answer. The surveyor also asked what were those dried substances on top of the table near the clean clothing and the DH did not respond.</p> <p>At that same time, the surveyor asked the DH when the laundry room was last cleaned, and if there was an accountability log for cleaning, the DH did not respond.</p> <p>On 4/25/24 at 11:57 AM, the surveyor and the DH then went to the room across from the Laundry area which was the Linen Storage Room. The DH claimed that the linen storage room was considered a clean area where the clean linens, bedsheets, gowns, blankets, and towels were located.</p> <p>Upon entry to the door, the surveyor observed a metal rack that was covered and the top portion had files of blankets that were not properly stored and left open to the surrounding environment.</p> <p>At that same time, the DH stated that those were clean blankets and they were delivered like that with no plastic. The surveyor asked the DH if that was appropriate or should the blankets stored properly and the DH stated the same They were delivered like that. The surveyor then asked the DH for the facility's policy regarding cleaning the laundry area and environment.</p> <p>A review of the provided facility's Handling Clean Linen Policy dated 01/01/2022 that was provided by the Licensed Nursing Home Administrator (LNHA) included that it is the policy of the facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. Definition of Linen, included sheets, blankets, pillows, towels, washcloths, and similar items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environmental services. Policy Explanation and Compliance Guidelines:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport, and unloading, such as:</p> <ul style="list-style-type: none"> a. Placing clean linen in a hamper lined with a previously unused liner, which is then closed or covered. b. Placing clean linen in a properly cleaned cart and covering the cart with disposable material or a properly cleaned reusable textile material that can be secured to the cart. c. Wrapping the individual bundles of clean textiles in plastic or other suitable material and sealing or taping the bundles. <p>5. Guidelines for the storage of clean linen include, but are not limited to, the following:</p> <ul style="list-style-type: none"> a. Clean linen shall be delivered to the resident care unit on covered linen carts with covers down. Nothing shall be kept on top of linen carts. Only rolls of bags used for linen cart transport may be kept on the carts, in the designated pockets only. <p>2. A review of the facility's Water Management Policy that was updated on 11/07/23 was provided by the [NAME] President of Clinical (VPoC) included the identified areas possibly subject to Legionella (bacteria can cause a serious type of pneumonia (lung infection) called Legionnaires' disease) and the control measures & corrective actions:</p> <ul style="list-style-type: none"> a. ice machines: the ice machine is cleaned and disinfected quarterly. b. dead legs: tour the building semi-annually to locate any discontinued or changed plumbing. c. less frequently used areas: both the hot and cold water are run for not less than 1 minute I all areas less used on a weekly schedule. d. water coolers: the water cooler is cleaned and disinfected quarterly. e. respiratory therapy equipment: used equipment is cleaned and disinfected weekly. f. HVAC_PTAC units: HVAC (heating, ventilation, and air conditioning is the use of various technologies to control the temperature, humidity, and purity of the air in an enclosed space) filters are cleaned quarterly. PTAC (a packaged terminal air conditioner is a type of self-contained heating and air conditioning system intended to be mounted through a wall) filters are cleaned monthly and a yearly schedule for complete unit cleaning for ten units a month. g. juice machine: juice gun is cleaned and disinfected daily by dietary. h. eyewash systems: these systems are checked weekly and run for less than 1 minute. <p>9. hot water holding tanks: the hot water holding tanks are flushed monthly.</p> <p>10. faucet aerators & shower heads: these items are cleaned and disinfected semi-annually.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/29/24 at 9:31 AM, the Director of Maintenance (DoM) and Director of Operations (DoO) informed the surveyor in the presence of the survey team that the facility was responsible for checking and monitoring water temperature. The DoO also stated that the rest of the water management areas were managed by the county. The DoM further stated that they had provided the water temperature accountability log as part of the surveyor's inquiry for what the facility was doing with regard to water management.</p> <p>On that same date and time, the surveyor asked the DoM and the DoO where were the control measures and corrective actions accountability log that the facility did as per facility's policy stipulated on 11/07/23 for water management. Both the facility management stated that they will get back to the surveyor.</p> <p>On 4/29/24 at 10:00 AM, two surveyors met with the DoM and the DoO. The DoO informed the surveyor that the facility had no accountability log for HVAC and PTAC because it was an outside contractor's responsibility who comes to the facility every first of the month. The DoO stated that there was no dead leg (a section of potable water pipe which contains water that has no flow or does not circulate) and no hot water tanks in the facility.</p> <p>On that same date and time, the surveyor asked the facility management if the facility did not have HVAC and PTAC as part of the facility's responsibility for water management and there were no dead leg and hot water tanks, why there were still at the facility's policy if they were not applicable. The DoO stated that the the water management policy was just handed to them (DoO and DoM) by regional corporate team and was not aware of the facility's policy. The DoO further stated that he can not answer who and when the water management policy was handed to them.</p> <p>At that same time, both facility management stated that there were no accountability log that the facility can provide with regard to the control measures & corrective actions that were stipulated in the 11/07/23 water management policy except for the water temperature log that was previously provided.</p> <p>On 4/29/24 at 10:48 AM, the surveyor interviewed the DH in the presence of the survey team. The surveyor asked if there was an accountability log for checking shower rooms and the DH stated that yes, and it was being checked by the DH and the Infection Preventionist/Licensed Practical Nurse (IP/LPN) weekly and there was a sheet that was being signed/checked off which the IP/LPN was taking care of when they do the rounds.</p> <p>Furthermore, the DH stated that it was not housekeeping department's responsibility to clean routinely the eye wash stations and the shower heads, and he did not know who was responsible for it.</p> <p>On 4/29/24 at 11:11 AM, the IP/LPN provided to another surveyor a copy of the Environmental Rounds Worksheet for Infection Prevention (EPRWFIP).</p> <p>A review of the provided EPRWFIP dated 4/17/24, area inspected was N3, by IP/LPN and DH, revealed that the that the 1st page was filled out while the pages 2, 3, 4, 5, and 6 was left blank.</p> <p>Further review of the EPRWFIP revealed that there was no accountability for checking the shower heads/shower room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to another surveyor, the IP/LPN informed the surveyor that the EPRW/IP was being done weekly together with the DH. The IP/LPN further stated that she was probably called to do something else that was why it was not completed the 4/17/24 inspection, and should have been completed.</p> <p>On 5/01/24 at 8:19 AM, the surveyor interviewed the IP/LPN. The IP/LPN stated that she was made aware during their exit meeting with facility management about the surveyor's concerns and findings. The IP/LPN further stated that we should have gone over with the policy over with staff designated for the water management and we should have a better understanding of each person's role.</p> <p>At that same time, the IP/LPN stated that it was important to follow the water management policy, to monitor monthly and as required, to ensure that no organism that will infect the building. The surveyor then asked the IP/LPN what happened why there was no accountability and the facility did not follow the facility's policy. The IP/LPN responded I don't know what happened, I can't answer that. The IP/LPN acknowledged that the facility's policy was based from the regulation, and the policy should have been followed.</p> <p>On 5/01/24 at 12:23 PM, the survey team met with the Medical Director (MD, also act as an Infection Disease Doctor of the facility). The surveyor asked the MD if he was made aware of the surveyors' concerns and findings about infection control and he stated yes, and the facility were looking at those concerns with water management and accountability. The MD also stated that the as he remembered, issue with infection control about water management were not discussed and identified in the QAPI (Quality Assurance and Performance Improvement, focuses on performance within a healthcare organization relative to clinical or non-clinical processes or outcomes).</p> <p>On 5/01/24 at 01:01 PM, the survey team met with the LNHA, Director of Nursing (DON), VPoC, and Administrator in Training (AIT). The surveyor notified the facility management of the above concerns and findings regarding the laundry area and water management.</p> <p>On 5/02/24 at 9:52 AM, the survey team met with the Director of Rehab, DON, LNHA, AIT, and VPoC. The VPoC acknowledged the above findings and concerns regarding the laundry area and water management. The VPoC stated that the facility's policy was based on the regulation, and that the maintenance department did not follow the facility's policy with regard to water management. She further stated that the facility should have an accountability log for water management. The VPoC also acknowledged that the facility had dead leg that should have been monitored in accordance to facility's water management policy.</p> <p>45449</p> <p>3) On 4/22/23 at 10:14 AM, the surveyor observed a signage outside Resident #105's room for EBP. Outside the resident's living space was a drawer stocked with masks. Above the drawer contained surgical gloves and next to the bin were two waste bins.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 4/22/23 at 10:16 AM, the surveyor entered the resident's room, and observed Resident #105 asleep, covered with a blanket and the head of the bed was elevated. The left-hand side of the resident's bed was next to a wall and on the right-hand side of the resident's bed was an IV (intravenous) pole. Hanging on the IV pole was a labeled enteral Tube Feeding (TF) formula bag that contained, light brown liquid, and an enteral TF hydration bag that contained, clear liquid that was uncapped. The TF pump was flowing at 80 milliliters (ml) per hour, had administered 1216 ml at that time, and was set to flush with 85 ml /hour.</p> <p>At 10:18 AM, the Certified Nursing Assistant (CNA) had walked into the joint vestibule of the resident's room. The CNA informed the surveyor that she was assigned to Resident #105 on that day but had not given morning care to the resident. The CNA had informed the surveyor that the morning care included washing, changing, and shaving.</p> <p>At that time, Registered Nurse (RN) had entered the room and informed the surveyor she was not assigned to the resident. The RN stated we fill the hydration bag with water and confirmed the hydration bag should have been capped. The RN left the room to locate the nurse assigned to the resident and inform the unit manager of the concern.</p> <p>4) On 4/22/23 at 10:32 AM, on the right-hand side of the resident's bed, the surveyor observed the urine catheter drainage bag (urine bag) was on the floor without a privacy cover and contained a light-yellow liquid. The urine catheter tubing (urine tubing) was also on the floor and contained light-yellow liquid. The urine tubing was intertwined with the resident's call bell that was hanging off the bed and the dangling remote.</p> <p>At 10:36 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) informed the surveyor that at 7:00 AM that morning, she had conducted a tour of her assigned unit that included Resident #105. The LPN stated the resident's TB formula and hydration bags were placed by the 3:00 PM to 11:00 PM shift nurse the night before.</p> <p>At that time, the LPN stated that the urine catheter drainage bag should have had a privacy cover and should not have been on the floor. The urine catheter tubing should not have been touching the floor. The urine catheter tubing should not have been intertwined with the call bell and remote. The LPN stated it was important to minimize the risk of infection.</p> <p>At that time, the LPN stated that the CNA who had emptied the urine catheter drainage bag must have forgotten to clamp the drainage bag back up. The LPN informed the surveyor she would inform her supervisor.</p> <p>The surveyor reviewed the medical records for Resident 105.</p> <p>According to the Admission Record, Resident #105 was admitted to the facility with diagnosis that included dementia (impairment of memory loss and judgment), without behavioral disturbance, gastrostomy status (resident with feeding tube), benign prostatic hyperplasia (enlarged prostate, symptoms include difficulty and sudden urge to urinate) and urinary retention.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Roosevelt Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 118 Parsonage Road Edison, NJ 08837	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 3/31/24, reflected a Brief Interview for Mental Status (BIMS) score of 10, which indicated that the resident was moderately impaired. Section H. Bladder and Bowel indicated the resident had an indwelling catheter.</p> <p>Further review of the qMDS dated [DATE], included Section K0520. Nutritional Approaches reflected the resident had a TF, and mechanically altered diet that required change in texture of food or liquids (pureed food and thickened liquids). Section K0710. Percent Intake by Artificial Route revealed that the average fluid intake per day by IV or tube feeding was 501 cc (cubic centimeter = 1 ml (milliliter)) per day.</p> <p>A review of the Order Summary Report included the following orders:</p> <ul style="list-style-type: none"> -Enteral Feed Order every hour provide free water automatic flush infuse via G/T (gastric tube; surgically placed tube into the stomach typically used for nutritional feedings) at 85 ml/hour until 1350 ml /24 hour (hr) was completed, started on 4/18/24. -Enteral Feed Order in the evening for dysphagia, Jevity 1.5 infused via G/T at 80 ml/hr until total volume of 1250 ml/hr was completed .started on 4/18/24. -Check Securement placement to secure Foley catheter tubing and prevent pulling of catheter tubing and catheter related injury stated on 4/19/24. <p>A review of the resident's Care Plan included a focus that the resident required EBP related to indwelling medical device, feeding tube, and indwelling urinary foley catheter initiated on 8/24/23. The interventions included educate resident, family, and care givers on standard precaution, contact precaution, droplet precautions and EBP, initiated on 8/24/23.</p> <p>On 4/23/24 at 11:59 AM, during an interview with the surveyor, the IP/LPN stated that during each feeding a new hydration bag was hung on the IV pole and filled with water to the graduated measurement on the bag and the TF pump was set to the physician ordered water amount. The closure on top of the bag had to snap in to ensure it was closed. The IP/LPN confirmed the cover should have been closed to ensure no contamination of the water occurred and for infection control precaution.</p> <p>At 12:06 PM, the IP/LPN stated that the urine bag should have had a privacy bag for the resident's dignity and should have been off the floor for proper infection control practices.</p> <p>At that time, the IP/LPN also stated that the urine tubing should have also been off the floor, and not intertwined with the hanging call bell and dangling remote, for proper infection control practices.</p> <p>On 4/25/24 at 10:18 AM, during an interview with the surveyor, the DON was informed of the concerns regarding the uncapped TF hydration bag, the urine bag on the floor, the urine tubing on the floor while intertwined with the hanging call bell and dangling remote.</p> <p>At that time, the DON stated when the incident occurred, she had been informed and the staff was instructed to discard the TF hydration water and was replaced. The DON also stated the urine bag and urine tubing should not have been on the floor to ensure they are sanitary.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/01/24 at 01:03 PM, in the presence of the survey team, the LNHA, the AIT, the VPoC and the DON the surveyor discussed the concerns regarding Resident #105's uncapped TF hydration bag, the urine bag on the floor, the urine tubing on the floor while intertwined with the hanging call bell and dangling the remote.</p> <p>A review of the facility provided Policy for Enteral Nutrition dated/revised November 2023 did not included a process to ensure the TF hydration bag was capped to prevent contamination or infection.</p> <p>A review of the undated facility provided policy for Catheter Indwelling Urinary Care, included the following:</p> <p>13. Secure catheter tubing to keep the drainage bag below the level of the patient's bladder and off the floor. Position catheter for straight drainage and keep catheter and tubing free from kinks.</p> <p>On 5/02/24 at 9:52 AM, in the presence of the survey team, the LNHA, the AIT, the DON and the Rehabilitation Director, the VPoC acknowledged the infection control concerns for Resident #105.</p> <p>NJAC 8:39-19.1(a), 19.4(a)(1), 21.1(a,d,g), 27.1(a)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327</p> <p>Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a safe and sanitary environment for: a) two (2) of two (2) rooms (Laundry and Linen Storage) and b) two (2) of two (2) shower rooms.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 4/25/24 at 11:41 AM, the surveyor in the presence of the Director of Housekeeping (DH) observed in the Laundry Room the following:</p> <p>Upon entry, there was a puddle of water near the door and the washer. There was one towel heavily wet with puddle water. The DH informed the surveyor that the puddle of water was from the washer and it was reported already to the maintenance department last week.</p> <p>The laundry room had one big garbage open container with stagnant water blackish in color with garbage and used surgical mask.</p> <p>One small garbage open container with stagnant black in color water with grayish substances. The DH stated that the grayish substance was a collection of lint.</p> <p>There was a big open pipe directly to the open small garbage container. The big open pipe was attached to the ceiling. There were three ceiling tiles next to a big open pipe, with brownish-dried discoloration. The DH stated that the ceiling tiles were being changed every two weeks because there was a leak in the ceiling.</p> <p>The laundry floor with blackish stains in the surrounding area, and some scattered grayish and whitish dried substances. The DH had no response when asked what those stains and scattered dry substances were.</p> <p>On 4/25/24 at 01:32 PM, the surveyor notified another surveyor about the above concern regarding an open pipe.</p> <p>On 4/25/24 at 01:37 PM, according to another surveyor, the open pipe should have been closed when the old dryer was removed. The other surveyor acknowledged the laundry condition and environment as mentioned above the concerns and findings of the surveyor.</p> <p>On 4/25/24 at 01:46 PM, the surveyor notified the Director of Nursing (DON) and VPoC regarding the above concern and findings.</p> <p>On 4/25/24 at 02:21 PM, the surveyor in the presence of the survey team interviewed the Regional Director of Property Operations (RDoPO) and the Director of Operations (DoO). The DoO informed the surveyor that the open pipe in the laundry room was a connection from a previously removed dryer. The DoO was unable to state when the old dryer was removed to determine how long the open pipe should have been removed and fixed.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On that same date and time, the surveyor notified the facility management of the above findings and concerns. The DoO stated that it is what it is, and that they will fix everything. He further stated that it was the responsibility of the DH and Maintenance Department to report it to the DoO because there was nothing he can do if it was not reported to his attention.</p> <p>Furthermore, the surveyor also asked the facility management if there were accountability log for the abovementioned concerns. The DoO responded that those concerns that were identified by the surveyor did not need a log or routine check to be fixed, they should have been reported to the DoO so I can do something about it. The DoO also stated that there was a breakdown of communication and now being addressed. He further stated that there was no accountability on cleaning and checking the laundry area, and even if there was a monitoring or log, the DH should not wait a day or so to report the problem.</p> <p>On 4/29/24 at 9:16 AM, the DoO provided a typewritten information that included the issue was the condensate pipe (which is designed to release water once the volume hits a certain threshold. occurs when the air around your pipes is significantly warmer than the water running through them) in the laundry room and not a leak. It also included in the typewritten information that a contractor would have to come to wrap the lines that were producing the moisture to try to eliminate any additional issues.</p> <p>The DoO did not provide information on when the old washer was previously removed which caused an open pipe and condensate pipes in the laundry room.</p> <p>2. On 4/29/24 at 10:20 AM, the surveyor toured the 3N shower room [ROOM NUMBER] (left side upon exit the elevator) with Director of Maintenance (DoM). Both the surveyor and DoM observed shower cubicle#1, #2, and #3 with shower heads that had a dried brownish discoloration around the shower head side and the middle part with whitish substances. The DM stated the dried brownish discoloration and whitish substances in the shower head was a hard water. The [branded] bath tub (built to help senior care communities and caretakers offer the best in bathing) was inside the shower room [ROOM NUMBER] and the DM was unable to determine when was the last time the tub was serviced and monitored or used.</p> <p>Afterward, both the surveyor and the DoM went to the 3N shower room#2 (right side upon exit the elevator). The shower cubicle#1 and 2 were both with hard water residue on all shower heads. The vent in the ceiling with accumulation of grayish substances which the DoM claimed dust. He stated that it was the responsibility of the housekeeping department to clean the vent.</p> <p>On 4/29/24 at 10:48 AM, the surveyor interviewed the DH in the presence of the survey team. The DH informed the surveyor that there were two housekeeping staff that were responsible for each shower rooms. He further stated that it was not his department's responsibility to clean the shower heads.</p> <p>On 4/29/24 at 11:02 AM, the surveyor interviewed housekeeper (HK). Both the surveyor and the HK went to shower room [ROOM NUMBER]. In the shower room both the surveyor and the HK observed the shower heads and the ceiling vent. The HK stated that she was responsible for cleaning the shower room daily but there was no accountability log. She indicated that she knew it was her responsibility to clean the shower head and the vent. She further stated that the grayish substances on the vent was accumulation of dust which probably been not cleaned for at least three days.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 5/01/24 at 01:01 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), [NAME] President of Clinical (VPoC), and Administrator in Training (AIT). The surveyor notified the facility management of the above concerns and findings regarding the laundry area and N3 unit shower rooms.</p> <p>On 5/02/24 at 9:52 AM, the survey team met with the Director of Rehab, DON, LNHA, AIT, and VPoC. The VPoC acknowledged the above findings and concerns regarding the laundry area and N3 unit shower rooms.</p> <p>NJAC 8:39-31.4 (a)(b)(f)</p>		