STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315509	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Care Center at Old Bridge	1133 Marlboro Road Old Bridge, NJ 08857

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, review of facility policy and review of the Resident Assessment Instrument (RAI), the facility failed to ensure four residents Minimum Data Set (MDS) assessments were accurately coded regarding dialysis (Resident (R) 6 and R135), weight loss (R14) and restorative nursing program (R8) out of 33 sampled residents. This failure had the potential to affect the care planning and provision of needed services.Findings include: 1.a. Review of the admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R6 was admitted to the facility on [DATE]. She had diagnoses of end stage renal disease and dependence on renal dialysis with an onset date of 10/01/24. Review of Nurses Notes, dated 07/26/25, 07/29/25, and 07/31/25, and located in the EMR under the Progress Notes tab revealed R6 was picked up by stretcher for dialysis and returned via stretcher following dialysis on those days. Review of R6's Order Summary Report, dated 08/01/25, and located in the EMR under the Orders tab revealed an order for: Dialysis center: . Pick up time 9:45am every shift every Tue, Thu, Sat for Hemodialysis. Review of R6's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/01/25 and located under the MDS tab of the EMR revealed the Staff Assessment for Mental Status indicated severely impaired decision-making skills. The MDS failed to code that R6 received dialysis while a resident of the facility and within the last 14 days. b. Review of the admission Record, located in the EMR under the Profile tab, revealed R135 was admitted to the facility on [DATE] and had diagnoses which included end stage renal disease and dependence on renal dialysis. Review of Nurses Notes, dated 07/17/25, 07/19/25, and 07/22/25, and located in the EMR under the Progress Notes tab revealed R135 was picked up for dialysis and returned following dialysis on those days. Review of R135's Order Summary Report revealed an order dated 10/24/23, indicated, Dialysis on Tuesdays, Thursdays and Saturdays at [dialysis center] Review of R135's annual MDS with an ARD of 07/23/25 and located under the MDS tab of the EMR revealed she scored a five out of 15 on her Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. The MDS failed to code that R135 received dialysis while a resident of the facility and within the last 14 days. During an interview on 09/25/25 at 10:46 AM, MDS Coordinator (MDSC) 2 reviewed R6's and R135's annual MDSs and stated they both received dialysis. This is my mistake. I will correct them. During an interview on 09/25/25 at 12:53 PM, the Regional MDS Coordinator (RMDSC) reported she expected dialysis which was received to be coded on the MDS. 2. Review of the admission Record, located in the EMR under the Profile tab, revealed R14 was admitted to the facility on [DATE] with diagnoses which included progressive supranuclear ophthalmoplegia (a neurodegenerative disease). Review of R14's Weights tab of the EMR revealed he weighed 158.8 pounds (lbs) on 07/18/25. The weights closest to six months prior were: 185.8 lbs on 01/05/25, which reflected a weight loss of 14.53%, and 184.4 lbs on 02/04/25 R14, which reflected a weight loss of 13.88%. Review of a Dietary/Nutrition Note, dated 07/21/24, and located under the Progress Notes tab of the EMR revealed R14 had, . 29.2 [lbs] weight loss x 193 days unplanned . Review of R14's significant change MDS with an ARD of 07/24/25 and located under the MDS tab of the EMR revealed he scored zero out of 15 on his BIMS which indicated severe cognitive impairment. The MDS revealed (continued on next page)

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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R14 weighed 159 lbs and had no or unknown weight loss of five percent (%) or more in the last month or loss of 10% or more in the last six months. During an interview on 09/25/25 at 10:55 AM, the Registered Dietitian (RD) reported weight loss was coded on the MDS for 30 days and 180 days. R14's weight loss at 30 days was 4.3%, which was not significant. The recorded weights closest to 180 days prior to the ARD date were taken on 01/05/25 and 02/04/25, which were 167 days prior to the date and over 190 days after the date. The RD stated she was instructed by corporate that if the weights were out of the 180-day timeframe not to code for weight loss. During an interview on 09/25/25 at 12:53 PM, the RMDSC reported when she went back 180 days from the ARD, R14's weights reflected a significant weight loss. The RD may have coded off the policy and not off the RAI Manual, which she expected staff to follow. Review of the facility's undated Weight Assessment and Intervention policy revealed, Significant Weight Changes are defined as: a. [greater than or equal to] 5% in 30 days +/- 4 days; and b. [greater than or equal to] 10% in 180 days +/- 4 days. Review of the RAI (Resident Assessment Instrument) Manual, dated 10/01/24 and located at https://www.cms.gov/medicare/quality/nursing-home-improvement/resident-assessment-instrument-manual revealed that to determine a 10% weight loss in 180 days, Start with the resident's weight closest to 180 days ago and multiply it by .90 [or 90%]. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight. 3. Review of the admission Record, located in the EMR under the Profile tab, revealed R8 was admitted to the facility on [DATE] and had diagnoses which included hemiplegia and hemiparesis following cerebral infarction (stroke) affecting the left non-dominant side. Review of R135's Order Summary Report revealed the following orders: active range of motion (AROM) for right lower extremity (RLE) daily as tolerated, dated 03/17/25; AROM for right upper extremity (RUE) daily as tolerated, dated 03/07/25, left elbow extension splint and left hand roll to be worn after morning care as tolerated and remove before evening care, dated 08/13/25; PRAFO (a type of ankle foot orthosis/splint) for his left lower extremity (LLE) from morning care to evening care, dated 06/14/24; passive range of motion (PROM) to his LLE as tolerated, dated 03/17/25, and PROM for left upper extremity (LUE) as tolerated, dated 03/07/25. Review of AROM for RUE and RLE daily in all planes as tolerated, located in the EMR under the Tasks tab, revealed staff documented that repetitions/sets were completed each day from 09/06/25 to 09/12/25; however, minutes were not recorded. Review of PROM for left arm and leg daily in all planes as tolerated, located in the EMR under the Tasks tab, revealed staff documented repetitions/sets completed on five days from 09/06/25 to 09/12/25; however, minutes were not recorded. Review of the task FMP [functional maintenance program] 1) left elbow extension splint and left hand roll to be worn after AM care as tolerated and remove before PM care, check skin for integrity; 2) PRAFO on left lower extremity, wedge near left hip, pillow by LLE to be worn after AM care or as tolerated Remove before PM care, Check Skin Integrity, locate in the EMR under the Tasks tab, revealed staff documented at least 15 minutes of splint or brace assistance on 09/06/25, 09/08/25, 09/09/25, 09/10/25, and 09/12/25. Review of R8's quarterly MDS with an ARD of 09/12/25 and located under the MDS tab of the EMR revealed he scored a 15 out of 15 on his Brief Interview for Mental Status (BIMS) which indicated intact cognition. The MDS revealed R8 had range of motion impairment to one side. It documented no days of restorative nursing to include days where splint or brace assistance was performed for at least 15 minutes a day. During a concurrent observation and interview on 09/22/25 at 1:35 PM, R8 was seated in his wheelchair with a blue padded splint on his left elbow, a left palm splint/hand roll, and a PRAFO on his left foot/leg, which he reported were placed daily. During an interview on 09/25/25 at 10:36 PM. Certified Nursing Assistant (CNA) 1 reported she assisted R8 each day with his elbow and palm splints as well as his PRAFO. She also completed range of motion for him, which maybe took ten minutes for both active and passive range of motion on her shift. During an interview on 09/25/25 at 10:46 AM, MDSC2 reported she was instructed not to document range of motion or splint assistance on the MDS because the facility had a functional maintenance program (FMP) and not a restorative program. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/25/25 at 11:04 AM, MDSC1 stated that only restorative programs were coded on the MDS. Functional maintenance was not coded. Functional maintenance was range or motion or splint care done during cares by the CNAs. During an interview on 09/25/25 at 11:33 AM, the Director of Nursing (DON) reported that therapy discharged residents to the FMP. Every CNA was trained on the FMP and provided it during resident care. It was different from restorative care because there were no specific restorative aides who provided the program. During an interview on 09/25/25 at 12:53 PM, the RMDSC reported the expectation that if there were at least 15 minutes a day documented under splint/brace care, it was coded on the MDS. If it's coded in the medical record, then it was to be documented in Section O of the MDS. Review of the facility's MDS 3.0 Completion policy, reviewed/revised on 01/01/21, revealed: All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment. NJAC 8:39-33.2(d)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the facility was able to provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care prior to the arrival of emergency medical personnel in accordance with related physicians orders and the resident's advance directives for three of five residents (Resident (R) R14, R184, and R187) reviewed for code status out of 36 sampled residents. This failure had the potential to cause basic life support needs to go unmet for residents who resided in the facility.Findings included: Review of the facility's policy titled, Communication of Code Status, dated February 2023, indicated, Policy: It is the policy of this facility to adhere to residents' rights to formulate advance directives. In accordance to these rights, this facility will implement procedures to communicate a resident's code status to those individuals who need to know this information. 2. When an order is written pertaining to a resident's presence or absence of an Advance Directive, the directions will be clearly documented in designated sections of the medical record. Examples of directions to be documented include, but are not limited to: a. Full Code b. Do Not Resuscitate c. Do Not Intubate d. Do not Hospitalize. 3. The nurse who notates the physician order is responsible for documenting the directions in all relevant sections of the medical record. 4. In the absence of an Advance Directive or further direction from the physician, the default direction will be Full Code. Review of the facility's policy titled, Advance Directives, revised [DATE], indicated, Policy Statement: Residents have the right to formulate an advance directive and to request, refuse, and discontinue treatments. If changes are made to the advance directive and/or POLST; healthcare provider orders shall be obtained to reflect the changes. 1. Record review on [DATE] at 9:42 AM of R184's undated admission Record located in the electronic medical record (EMR) under the Profile tab, revealed R184 admitted to the facility on [DATE] and the Advance Directive section was blank. Review of R184's Resident Header did not reflect a code status or an Advance Directive. Record review on [DATE] at 9:44 AM of R184's undated Order Summary Report located in the EMR under the Orders tab, did not reflect an order pertaining to R184's presence or absence of an Advance Directive, further direction from the physician, or the default direction as Full Code (the healthcare team will do everything in their power to keep the patient alive). Review of R184's Social Services Assessment & SPN, dated [DATE], located in the EMR under the Assmnts tab, reflected information was provided regarding Resident Rights / Health Care Decision Making / Advance Directives Status but did not reflect R184's wishes for Full Code, Do Not Resuscitate (DNR) (instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if the patient's heart stops or breathing ceases), or Do Not Intubate (DNI) (a medical directive that instructs healthcare providers not to perform intubation, a procedure in which a tube is inserted into the patient's airway to assist with breathing). Review of R184's undated Care Plan Report located in the EMR under the Care Plan tab, revealed a Social Worker entry that indicated [R184] was a full code (Date Initiated: [DATE]). The Goal was to honor [R184's] wishes (Date Initiated: [DATE]; Target Date: [DATE]). The Interventions/Tasks included Ensure that orders reflect full code wishes. (Date initiated: [DATE]). Review of the Misc tab, located in the EMR, did not reveal a New Jersey Practitioner Orders For Life-Sustaining Treatment (POLST) or other Advance Directives that specified R184's healthcare wishes. During an interview on [DATE] at 1:59 PM, R184 stated her Full Code wishes. R184 said that she was presented with Advance Directive resources that morning ([DATE]) and that she told the unnamed staff member that she did not want to talk about that and wanted the facility to use all measures to keep her alive. Record review on [DATE] at 2:15 PM of R184's undated Order Audit Report located in the EMR under the Orders tab, revealed an order entered on [DATE] at 3:35 PM for Full Code. 2. Record review on [DATE] at 12:15 PM of R187's undated admission Record located in the EMR under the Profile tab, (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed R184 admitted to the facility on [DATE] and the Advance Directive section was blank. Review of R187's Resident Header or an Advance Directive. Record review on [DATE] at 12:19 PM of R187's undated Order Summary Report located in the EMR under the Orders tab, did not reflect an order pertaining to R187's presence or absence of an Advance Directive, further direction from the physician, or the default direction as Full Code (the healthcare team will do everything in their power to keep the patient alive). Review of R187's Social Services Assessment & SPN dated [DATE], located in the EMR under the Assmnts tab, reflected information was provided regarding Resident Rights / Health Care Decision Making / Advance Directives Status but did not reflect R187's wishes for Full Code, DNR), or DNI) (a medical directive that instructs healthcare providers not to perform intubation, a procedure in which a tube is inserted into the patient's airway to assist with breathing). Review of R187's undated Care Plan Report located in the EMR under the Care Plan tab, revealed a Social Worker entry that indicated [R187] was a full code (Date Initiated: [DATE]). The Goal was to honor [R187's] wishes (Date Initiated: [DATE]; Target Date: [DATE]). The Interventions/Tasks included Ensure that orders reflect full code wishes. (Date initiated: [DATE]). Review of the Misc tab, located in the EMR, did not reveal a New Jersey Practitioner Orders For Life-Sustaining Treatment (POLST) or other Advance Directives that specified R187's healthcare wishes. During an interview on [DATE] at 1:51 PM, the Social Worker (SW) stated that she interviewed the residents on admission to the facility to discuss CPR vs Advance Directive wishes. The SW stated if a resident was unable to decide or did not have an Advance Directive the resident was considered a Full Code unless otherwise documented as DNR/DNI. During an interview on [DATE] at 1:54 PM, R187 stated her Full Code wishes. R187 said that she was presented with Advance Directive resources that morning ([DATE]) and that she and her husband would review the resources for decision-making about an Advance Directive. R187 stated she was aware that the facility would use all appropriate measures to sustain life. During an interview and record review on [DATE] at 2:10 PM, Licensed Practical Nurse (LPN) 3 indicated the admission nurse would discuss the predetermined wishes regarding medical interventions in the event of a life-threatening emergency, such as cardiac or respiratory arrest with the resident during the admission interview. LPN 3 said that the nurse would indicate on the New Jersey Practitioner Orders For Life-Sustaining Treatment (POLST) if the resident wanted Full Treatment; Limited Treatment; or Symptom Treatment Only as medical interventions (when a person was not breathing and/or no pulse). LPN 3 indicated that the Full Code, DNR/DNI decision was entered as an order and would reflect on the header in the resident chart. If medical interventions were undetermined, the resident was considered a Full Code until otherwise determined. LPN 3 stated that the resident code status was also listed under the Code Status tab, in the EMR. Review of R184's and R187's chart with LPN 3 revealed that there was not a code status listed, there was not a POLST form uploaded, and there was not an order for Full Code, DNR, or DNI in either chart. During an interview on [DATE] at 11:36 AM, the Director of Nursing (DON) indicated that a code status was obtained during admission. The DON said that her expectations, and per policy, was to enter an order pertaining to a resident's presence or absence of an Advance Directive. The DON said that the default code status was Full Code if the resident did not have an Advance Directive. The DON said that code statuses were reviewed in daily clinical meetings following a resident admission to the facility. The DON could not explain why R184 and R187 did not have a code status order entered on admission to the facility. Record review on [DATE] at 2:14 PM of R187's undated Order Audit Report located in the EMR under the Orders tab, revealed an order entered on [DATE] at 3:39 PM for Full Code. 3.Review of the admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R14 was admitted to the facility on [DATE] with diagnoses which included progressive supranuclear ophthalmoplegia (a neurodegenerative disease). Review of a Nurses Note dated [DATE] and located in the EMR under the Progress Notes tab revealed R14's responsible party signed an updated New Jersey Practitioner Orders for Life-Sustaining Treatment (POLST) to change R14's code status from full code) to DNR. and DNI. Review of a POLST form, dated [DATE], and located in the EMR under the (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Misc tab revealed that Do not attempt resuscitation was checked. Review of the Care Plan tab of the EMR revealed a focus area revised on [DATE]: [R14] is a DNR/DNI with an intervention revised [DATE], ensure orders reflect DNR/DNI code wishes. Review of another POLST form, dated [DATE], and located in the EMR under the Misc tab revealed that Do not attempt resuscitation was checked. Review of R14's Order Recap Report from [DATE] to [DATE] and located in the EMR under the Orders tab revealed an order for DNR, DNI from [DATE] to [DATE]. The order was discontinued when R14 went out to the hospital, and no current order was entered as of [DATE]. Review of R14's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] and located under the MDS tab of the EMR revealed he scored zero out of 15 on his Brief Interview for Mental Status (BIMS) which indicated severe cognitive impairment. During an interview on [DATE] at 12:57 PM, LPN1 reported when a family decided to change a resident's code status, a new POLST was completed and signed by the family and practitioner. Nursing entered the orders under the Orders tab of the EMR and updated the gray section of the resident's profile in the EMR. The POLST form went in front of the resident's hard chart. When she needed to know a resident's code status choice, she reviewed the order and special instructions (gray section of the profile) in the EMR and also the POLST if there was no order. LPN1 verified there was no order regarding code status for R14 in the EMR but stated she knew R14's family requested him to have DNR status and referred to the POLST form in his paper chart. During an interview on [DATE] at 1:25 PM, LPN2 referred to the special instructions of the EMR to determine a resident's code status preference. LPN2 reviewed R14's special instructions and stated he was DNR/DNI. There were also POLSTs in the paper charts. During an interview on [DATE] at 11:42 AM, the DON stated the social worker spoke to the family regarding code status and then relayed the choice to nursing. Nurses were expected to enter orders into the EMR when a new POLST was signed. R14's orders were expected to be re-instated when he returned from the hospital in July. NJAC 8:39-14.2(b)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received alternative measures prior to installation of bedrails, obtain physician's order for bedrail, and care plan the bedrail for one of two residents reviewed for bedrails (Resident (R) 112) of 30 sampled residents. The lack of alternative bedrail measures, orders, and care plan could lead to potential safety concerns related to bed rail use for residents with bed rails. Findings include: Review of the facility's policy titled, Enablers updated 10/19 indicated An enabler limits a person's normal freedom of movement and can only be used after appropriate clinical assessment and requires voluntary agreement with the user. Items that constitute an enable include, but are not limited to, bedrails, tray tables, chair that patient cannot move out of independently. The use of enablers is a clinical decision by the inter-disciplinary team (IDT), and is made in partnership with the patient and family/[whanau] following an assessment of risks and benefits as they apply individually to the patient. IDT team are responsible for the assessment of risks, safety and the appropriateness of enabler use. Where enablers are used the clinical rationale for use and the monitoring requirements are to be documented in the patient's care plan and clinical record. The policy did not indicate that alternatives to use of bedrails were to be evaluated and the attending physician was consulted prior to the installation of bedrails. Review of R112's admission Record located under the Profile tab in the resident's electronic medical record (EMR) indicated the resident was admitted to the facility on [DATE]. Review R112's quarterly Side Rail Assessment Screening, dated 06/23/25 and located in the resident's EMR under the Assessment tab indicated R112 was evaluated for 1/2 side rails used for positioning, mobility, and transfers. Signed consent in place. The document did not include if alternatives were evaluated. Review of R112's Side Rail Assessment Screening, dated 06/19/23 and located in the resident's EMR under the Assessment tab indicated R112 was evaluated for the use of side rails at the time of her admission. The document did not include if alternatives were evaluated prior to the installation of bedrails Review of R112's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/23/25, located in the resident's EMR under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. The assessment revealed the resident did not have a fall during this assessment period. The assessment included the resident required supervision or touching assistance for bed-to-chair transfers. Under the Care Area Assessment (CAA), the resident triggered for falls and directed the staff to develop a care plan. Review of R112's Care Plan located in the resident's EMR under the Care Plan tab dated 06/19/23 indicated the resident had an Activity of Daily Living (ADL) self-care performance deficit r/t limited mobility. The interventions included the resident required assistance by staff to turn and reposition in bed as necessary. The care plan also included the resident was at risk for falls. There was no evidence to indicate the resident used the siderail for a positioning aide. Review of R112's Physician's Orders located under the Orders tab of the EMR, did not include an order for siderails. Review of R112's Progress Notes located under the Prog Notes tab of the EMR, did not include evidence that alternatives were attempted prior to the implementation of siderails. During an observation on 09/22/25 at 12:58 PM, R112 was sitting in her wheelchair at bedside. R112's bed had a one-half siderail engaged on the right upper side of the bed. During this observation, the resident stated she used the siderail to pull herself up out of bed. During an interview on 09/25/25 at 12:18 PM, the Director of Nursing (DON) stated they obtain a consent for siderails at admission, complete an assessment for siderails on admission and quarterly. Siderails are enablers and do not need a physician order or care plan since it is not a restraint and is just an enabling device. The DON was unable to provide evidence during this interview on any alternatives attempted prior to the use of side (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rails for the resident. During an interview on 09/25/25 at 1:32 PM, Registered Nurse (RN) 3 stated a siderail assessment is completed on admission after checking with the resident on their preference. A conversation is conducted with the resident regarding alternatives for security and safety and options are given. We get a signed consent, care plan, and doctor's order for the siderails, but needed to confirm with her supervisor on the process. After RN3 confirmed with Unit Manager (UM) 1, RN3 stated a care plan was not needed and did not need a doctor's order for siderails. RN3 confirmed the right upper siderail was engaged on R112's bed. During an interview on 09/25/25 at 1:40 PM, the Registered Nurse Risk Manager (RM) stated nurses do an assessment and get a signed consent for siderails. A care plan and physician order are not required because it is not a restraint. RM stated she wasn't sure and needed to ask UM1. During an interview on 09/25/025 at 1:41 PM, UM1 stated nurses just do assessments and get signed consent on admission. A care plan and physician's order are not required for siderails since they are not restraints. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315509	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Care Center at Old Bridge	1133 Marlboro Road Old Bridge, NJ 08857

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observations, record reviews, interviews and policy review, the facility failed to honor known food preferences for one of three residents (Resident (R) 187) reviewed for food choices out of 43 sampled residents. This failure had the potential to cause nutritional needs to go unmet for residents who consumed food prepared from the facility's kitchen. Findings included: Review of the facility's policy titled, Dining and Food Preferences, revised 10/2022, indicated, Policy Statement: Individual dining, food, and beverage preferences arc identified for all residents/patients. 2. The Dining Services Director, or designee, will interview the resident or resident representative to complete a Food Preference Interview within 72 hours of admission. The purpose of this interview will be to identify individual preferences for dining location, meal times, including times outside of the routine schedule, food and beverage preferences. 4. Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in the menu management software system. 5. The Registered Dietitian/Nutritionist (RDN) or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents/patients that do not consume certain foods or food groups. 7. The individual tray assembly ticket will identify all food items appropriate for the resident/patient based on diet order, allergies & intolerances, and preferences. Review of the facility's policy titled, Menus, revised 10/2022, indicated, Policy Statement: Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guide. 6. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. Review of R187's entry Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/17/25 located in the electronic medical record (EMR) under the MDS tab, reflected an admission date of 09/17/25. Review of R187's Baseline Care Plan, completed on 09/18/25 by Registered Nurse (RN) 2, did not reflect R187's dietary preferences. During an interview on 09/22/25 at 11:31 AM, R187 stated that she needed to speak with the dietician to further discuss her Vegan food preferences or an alternative. R187 stated her food preferences were selected from a three-week Vegan menu provided by the facility on 09/18/25, the day after she admitted to the facility. R187 said that the meals she received consisted of basically bread, oatmeal for breakfast, a roll, and vegetables for dinner. During an interview on 09/24/25 at 4:50 PM, R187 stated that she declined her dinner tray and sent her family member who was visiting out to pick her up something for dinner. Observation and interview on 09/24/25 at 4:55 PM revealed Certified Nursing Assistant (CNA) 2 passing dinner trays on the 300-Hall. CNA 2 indicated R187 refused her dinner tray. CNA 2 agreed to present R187's dinner tray that was on the meal delivery cart. R187's tray slip was torn in half on the meal tray. CNA 2 indicated R187's tray ticket was ripped in half because she declined her meal. R187's meal tray revealed a dinner plate with 1-dinner roll, potatoes, and vegetables, 2-small portion cups of fruit, and a plastic mug covered with a plastic lid. R187's tray ticket reflected Wednesday, 09/24/25, 1 ea.-Dinner Roll/Bread, 1 ea.-Margarine, 2 ea.-Fresh Fruit, 1/2 cup-Oven Browned Potatoes, 1/2 cup-Squash Medley, 8 oz.-Lactaid Milk, and 6 oz.-Coffee or Hot Tea. CNA 2 said it was her responsibility to check that the meal tray and tray ticket matched before the resident was served. CNA 2 said that the 8 oz.-Lactaid Milk was missing from the meal tray although it was listed on the tray ticket. During an interview on 09/24/25 at 5:15 PM, the Director of Nursing (DON) compared R187's meal tray and tray ticket. The DON stated the dinner tray was appropriate for a Vegan meal and as listed on the tray ticket as a Milk Plant Based Only meal. The DON said that R187's dinner was served as written on the menu for the day (09/24/25) and any concern about what was served should be discussed with the dietician. The DON stated the Dietary Manager (DM) would have more information about a resident's (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diet and food preferences. Observation on 09/25/25 at 9:10 AM revealed R187 was served a bagel, fresh fruit, English muffin, and oatmeal. Review of R187's tray slip served with this meal identified the items served. During an interview and record review on 09/25/25 at 9:45 AM, the DM stated that each resident was provided with a menu upon admission and meets with the dietician to discuss food choices and alternatives. The DM said that the dietary clerk or the executive chef entered the resident's food choices into the menu management system that generated the tray tickets. The DM said that she kept the resident menus that reflected the choices made for each primary meal. During an interview and record review on 09/25/25 at 9:50 AM, the Dietary District Manager (DDM) printed R187 tray tickets for all meals served on Wednesday, 09/24/25, the breakfast tray ticket for Thursday, 09/25/25, and the Week 4 Lacto-Ovo Vegetarian menu. The DM located R187's menus with her food selections and provided them to the DDM. R187 selected Tofu on a Bun, Oven Browned Potatoes, and Squash Medley for dinner on Wednesday and Egg & Hashbrown Bake, English Muffin, and Coffee for breakfast on Thursday. The DDM reviewed 187's menu selections and the dated tray tickets. The DDM indicated that R187 did not receive her preference as selected. The DDM said that R187 preferences were not entered into the menu management system correctly. During a continued interview on 09/25/25 at 10:15 AM, the DM confirmed R187 was not served her food preferences as selected on the menu on 09/24/25 at dinner or on 09/25/25 at breakfast. NJAC 8:39-17.4(c)