STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315126	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop McCarthy Center for Rehab & Healthcare	1045 E Chestnut Ave Vineland, NJ 08360

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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	COMPLAINT #2572162 Based on observations, interviews, medical record review, and review of other pertinent facility documentation on 7/31/25 and 8/1/25, it was determined that the facility failed to provide adequate supervision for a resident with cognitive impairment who required assistance with all activities of daily living and accompaniment to outside doctor's appointments and was sent to an out-of-state doctor's appointment and eloped. This deficient practice was identified for 1 of 3 residents reviewed for accidents (Resident #1). On 7/23/25 at 10:15 A.M., Resident #1 was sent to an out-of-state (OOS) doctor's appointment unaccompanied via medical transport. At 4:00 P.M., the facility received a telephone call from the OOS provider's office that Resident #1 could not be located. The facility received another telephone call on 7/24/25 at 8:30 P.M., that the resident was found at a nearby park approximately twenty-eight and a half hours later. Resident #1 was transported to the hospital and admitted for five days with an acute kidney injury that was likely due to dehydration and was discharged on 7/29/25. The facility's failure to provide adequate supervision for Resident #1 placed Resident #1 and all other residents who required supervision during off-site doctor's appointments at risk for elopement. This posed the likelihood for serious harm, injury, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 7/23/25 at 4:00 P.M., after Resident #1 was unaccompanied at an OOS doctor's appointment and eloped. The facility was notified of the IJ on 8/1/25 at 3:21 P.M. The facility submitted an acceptable Removal Plan (RP) on 8/5/25 at 10:27 A.M. The surveyor verified the implementation of the RP on-site on 8/6/25 at 3:34 P.M. The evidence was as follows A review of the facility's Transportation policy with an effective date of 03/2020, revealed that, Social services or charge nurse will be responsible for arranging transportation., and that, A member of the nursing staff or social services will make arrangements to have a resident accompanied at a diagnostic appointment as required . A review of the Facility Reportable Event (FRE) sent to the New Jersey Department of Health (NJDOH), indicated that on 7/23/25 at 10:15 A.M., Resident #1 was picked up from the facility and transported to an OOS provider appointment by an escort assigned by the OOS provider. The facility then received a call at 4:00 P.M. from the OOS provider's office asking if the resident had returned to the facility as the resident could not be located. The FRE indicated that the resident had been seen and when they went to retrieve them, the resident could not be located. The facility determined that the resident had yet to return, and the OOS provider initiated a search. The facility next received a call from the OOS provider stating that the facility found Resident #1's wheelchair at 7/23/2025 at 6:00 P.M. The FRE further indicated that the OOS provider called a code and continued to search for the resident. According to the admission Record face sheet, Resident #1 was admitted to the facility with diagnoses which included but were not limited to: degenerative disease of the nervous system, abnormalities of gait and mobility, schizophrenia, and bipolar disorder. A review of Resident #1's Minimum Data Set (MDS), an assessment tool dated 6/20/25, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that the resident's cognition was moderately impaired. A further review of the MDS revealed in Section GG, Functional Abilities, that the resident required assistance with all aspects of self-care. This section also indicated that Resident #1 required assistance with transitioning from sitting-to-standing, toilet transfer, and walking. A review of Resident #1's care plan (CP) included but were not limited to the following focus areas:-Activities of daily living (ADL) self-care deficit initiated 6/15/25, with a goal that the resident would, .receive assistance necessary to meet ADL needs. -At risk for falls due to impaired mobility, tardive dyskinesia (movement disorder), hypertension (high blood pressure), diabetes mellitus, psychotropic medication, abnormalities of gait and mobility initiated 6/15/25. An intervention included that the resident would be provided with assistance as needed.-Neurological deficiencies related to disease process and neurocognitive disorder initiated 6/16/25, with a goal that the resident would have ADL needs met with staff assistance. A review of Resident #1's Progress Notes (PN) revealed a Nursing Note dated 6/18/25 at 12:05 P.M., that the resident had a virtual psychiatrist visit with the [provider named redacted], and that the resident would be transported to a local [provider named redacted] every four weeks for an injection. The note indicated that the [provider name redacted] would provide transport with medical transport and a person to go with [them]. During the visit, when asked where the resident was, the resident answered in a [provider name redacted] hospital [out-of-state] for about a year, [they] were fifteen years old and stated [they] were in boot camp and that [their] legs and back hurt from all the training. When asked the year, [they] stated 2000 something I have to look at the calendar. A further review of the Progress Notes did not include any