

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315177	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Gateway Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 139 Grant Ave Eatontown, NJ 07724	

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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on observation, interviews, and a review of medical records and pertinent facility documents on 11/12/25, it was determined that the facility failed to provide adequate supervision to a severely cognitively impaired resident (Resident #2) with a known history of wandering behaviors, who eloped from the facility on 10/29/25. The deficient practice was identified for 1 of 5 residents reviewed for elopement (Resident #2). During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25 (d)(2) F 689, as the facility failed to provide adequate supervision to a severely cognitively impaired resident (Resident #2) with a known history of wandering behaviors who eloped from the facility on 10/29/2025. Registered Nurse (RN) #1 who was assigned to Resident #2 last observed the resident at approximately 4:45 p.m. on 10/29/2025. At approximately 5:05 p.m. Resident #2's assigned Certified Nurse Aide, (CNA) #1 went to the resident's room and observed the resident was not in there. CNA #1 then initiated a search for the resident in the dining room, and the resident was not found. At that time, CNA #1 alerted all staff and informed them that Resident #2 could not be located. A Code Gray (elopement/missing person code) was initiated, and staff members proceeded to search for the resident. The local police contacted the facility at approximately 5:45 p.m. and informed them that they found Resident #2 in a nearby town. The police returned Resident #2 to the facility at 6:00 p.m. The facility assessed Resident #2 with no injury. The facility's failure to provide the adequate supervision to a severely cognitively impaired resident with history of wandering behaviors and at risk for elopement and eloped, posed a likelihood of serious harm, injury, impairment or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began 10/29/25 at approximately 4:45 p.m. when resident was last seen by staff in the facility. The facility Administration was notified on 11/12/25 at 4:17 p.m The facility submitted an acceptable Removal Plan (RP) on 11/13/25 3:34 p. m The surveyor verified the implementation of the RP during the continuation of the onsite survey on 11/17/25 at 1:32 p.m. The evidence was as follows:A review of the facility's policy, undated, Elopements and Wandering Residents included: Policy This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk.Policy Explanation and Compliance Guidelines 1. Wandering is random or repetitive locomotion that may be goal-directed (e.g., the person appears to be searching for something such as an exit) or non-goal directed or aimless.2. Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.5. The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. 6. Monitoring and Managing Residents at Risk for Elopement or Unsafe Wandering . d. Adequate supervision will be provided to help prevent accidents or elopements.The Facility Reportable Event record (FRE) dated 10/29/2025, which the facility submitted to the New Jersey Department of Health (NJDOH) revealed that on 10/29/2025, at approximately 7:00 PM, Resident #2 exited the facility without staff knowledge and returned safely. Also, when the resident returned to the facility, they exhibited increased agitation, refused skin assessment and stated, This is not my home, I did not want to stay here. Resident #2 was transferred to hospital due to aggressive behavior. A review of an untitled facility document dated 10/29/2025 revealed the following:On 10/29/2025, Resident #2 was last seen on the nursing unit at approximately 4:45 p.m., by Registered Nurse (RN) #1, who was assigned to the resident. At approximately 5:05 p.m. Resident #2's assigned Certified Nurse Aide (CNA) #1 went to the resident's room and observed the resident was not in their room. CNA #1 then initiated a search for the resident in the dining room, and the resident could not be found. At that time, CNA #1 alerted all staff and informed them that Resident #2 could not be located. A Code Gray (elopement/missing person code) was initiated. The staff performed an extensive search of the entire facility premises. It was determined that Resident #2 was missing. The local police contacted the facility at approximately 5:45 p.m. and informed them that they found Resident #2 in a nearby town. The police returned Resident #2 to the facility at 6:00 p.m. The facility assessed Resident #2 with no injury. However, Resident #2 exhibited increased agitation and was sent to the hospital for evaluation. On 11/14/2025 at 2:48 n.m. the surveyor requested and received a copy of the Police Officer's Report from the town the resident</p>		