STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315198	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adroit Care Rehabilitation and Nursing Center	1777 Lawrence Street Rahway, NJ 07065

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. COMPLAINT #NJ185510 Based on interviews, record reviews, and review of other facility documentation, on 05/08/25 and 05/09/25, it was determined that the facility failed to provide a requested medical record for a discharged resident within 2 days of a written request. This deficient practice was identified for 1 of 3 residents, reviewed (Resident #6), and was evidenced by the following: Resident #6 was not at the facility at the time of the survey. A closed record review was conducted. According to the Resident Face Sheet, Resident #6 was admitted to the facility with diagnoses which included but were not limited to: Alzheimer's Disease, Dementia, Respiratory Disorder, and Chronic Pulmonary Obstructive Disease. The face sheet also revealed that a family member (FM) requesting the Resident's medical record was listed in the Contacts section as Primary, listed the FM's relationship to the resident, and under designation PHI: [protected health information] Full. According to the admission Minimum Data Set (MDS), an assessment tool dated 04/03/25, Resident #6 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated that Resident #6 was severely cognitively impaired. The surveyor reviewed a timeline provided by the facility Administrator (ADM) on 05/09/25 regarding a FM's written request for the medical record for Resident #6. According to the timeline, on 4/07/2025, the FM requested the medical records. The contracted provider of the medical record informed the facility ADM they required documentation demonstrating the requestor was the personal representative of the resident and had the authority to request the records. According to the timeline, the next communication was on 4/21/2025 at 5:03 pm from the ADM to the FM that supporting documentation was required. The facility did not follow up with the FM in a timely manner with this new request for information to ensure receipt of the medical record within 2 days of the 4/07/2025 request. The surveyor reviewed emails provided by the Administrator for review: -4/7/25 at 4:04 P.M.: Email sent from facility to the Contracted Provider containing the medical record request from the family. (continued on next page)

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-4/7/25 at 4:21 P.M.: Email sent from the Contracted Provider to the facility advising that additional documentation was needed prior to approving the release of records. The current Medicaid Coordinator (MC), whose role was Medical Records personnel at the time of the FM request on 4/07/2025, was interviewed on 5/08/2025 at 4:37 PM. The MC stated she was aware the FM filed a request for the resident's medical record. The MC further stated she did not deal directly with the family regarding the medical record request but was copied on the emails regarding the request. On 05/08/25 at 5:08 P.M., the surveyor interviewed the Administrator (ADM), who stated that to obtain a resident's medical record, a form must be completed, and then the facility would send the request to [Contracted Provider Name]. The ADM further explained that this provider was the facility's legal consultant who reviewed each request and informed the facility if the person requesting was legally entitled to the information or if additional documentation was needed. According to the ADM, the request for the medical record was received from Resident #6's FM and was sent to the Contracted Provider for review on 04/07/25. The Administrator also stated that he received a response from the Contracted Provider on the same day, 04/07/25 and that the provider advised that additional documentation was needed prior to releasing the records. The Administrator stated that he informed the family of the need for additional documentation on 04/21/25 when he next returned to the facility. When the surveyor asked why the facility did not send the request for additional information to the family member sooner, the Administrator stated that he could have delegated the task to someone else but that he did not. N.J.A.C. 8:39-35.2(h)