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	09/02/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Complaint: 2600629, 2601350Based on interviews, medical records review, and review of other pertinent facility documentation on 8/29/2025 and 9/02/2025, it was determined that the facility failed to report a resident elopement to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 3 sampled residents (Resident #1) and was evidenced by the following: According to Resident #1's admission Record (AR), the resident was admitted to the facility with diagnoses that included but was not limited to: vascular dementia with mood disorder (commonly known as memory and thinking problems caused by poor blood flow to the brain along with mood changes). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 8/21/2025, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated the resident had a moderately impaired cognitive status. A review of the Progress Notes (PN) included a Nursing Note dated 8/22/2025 at 7:18 P.M., that the nurse saw Resident #1 around 3:10 P.M., well dressed with cellphone in hand. At 3:15 P.M., when the nurse returned from the end of the hallway, the resident stated they wanted to sit outside. The nurse said okay, and documented that the physician was informed to get an out on pass order. Unfortunately, [the resident] decided to walk away from the building while out on pass and police found [the resident] away from the building. [The resident] was accompanied by the police to the police precinct. The Director of Nursing (DON) and the writer were contacted. Due to a syncopal (loss of consciousness) episode at the police precinct, [the resident] had to be transferred to the emergency room for evaluation. A review of the facility's undated REPORT OF INVESTIGATION revealed under 6. Conclusion of investigation: It was concluded that [Resident #1] who is alert and oriented BIMS 12 verbalized desire to go for a walk and sit outside for a while. Order for Out on Pass obtained and signed by [Resident #1] .During out on pass [they] walked away. Returned to facility later in the evening, safe. Body check done, no signs of injury. Wander guard was placed on [Resident #1] for extra safety. Care plan updated.During an interview on 8/29/2025 at 1:14 P.M., with the Licensed Nursing Home Administrator (LNHA) and DON, the surveyor asked if the elopement was reported to the NJDOH. The DON stated that after reviewing the incident they determined that reporting to the NJDOH was not necessary since they had a physician's order and an out on pass signed.A review of the medical record did not include a physician's order at the time of the incident for the resident to go out on pass unescorted. A review of the facility's policy titled ACCIDENTS/INCIDENTS INVESTIGATION PROCESS dated 6/05/25, revealed under REPORTABLE EVENTS that The results of all investigations will be reported to the administration of his or her designated representative and to other officials in accordance with State law, including the State Agencies, within 5 working days of the incident with appropriate corrective action taken as a result of the investigation.NJAC 8:39-9.4(f)

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 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 Level of Harm - Actual harm Residents Affected - Few	Complaint: 2600629, 2601350Based on interviews, review of medical records, and review of other pertinent facility documentation on 8/29/2025 and 9/02/2025, it was determined that the facility failed to a.) implement a resident's (Resident #1) comprehensive care plan for out on pass with escort only which resulted in the resident eloping and b.) develop a care plan for a resident post elopement. On 8/22/2025, Resident #1 was sitting outside the facility unescorted and was found wandering on a multi-lane highway by a passerby who brought the resident to the police precinct and had a syncopal episode (loss of consciousness) and was transferred to the emergency room.This deficient practice was identified for 1 of 3 sampled residents (Resident #1) and was evidenced by the following: According to Resident #1's face sheet, the resident was admitted to the facility with a diagnoses that included but was not limited to: vascular dementia with mood disorder (commonly known as memory and thinking problems caused by poor blood flow to the brain along with mood changes). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 8/21/2025, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated the resident had a moderately impaired cognitive status. A review of the Progress Notes (PN) included a Nursing Note dated 8/22/2025 at 7:18 P.M., which indicated the nurse saw Resident #1 around 3:10 P.M., well dressed with a cellphone in hand. At 3:15 P.M., when the nurse returned from the end of the hallway, the resident stated they wanted to sit outside. The nurse said okay, and documented that the physician was informed to get an out on pass order. Unfortunately, [the resident] decided to walk away from the building while out on pass and police found [the resident] away from the building. [The resident] was accompanied by the police to the police precinct. The Director of Nursing (DON) and the writer were contacted. Due to a syncopal episode at the police precinct, [the resident] had to be transferred to the emergency room for evaluation. A review of the Physician's Orders (PO) on 08/29/2025, did not include a PO for the Resident #1 to go out on pass at the time of the incident. On 8/29/2025, the surveyor reviewed Resident #1's Care Plan (CP) dated 5/29/2025, with no revision date. The CP's focus revealed Nursing: Community Pass As Evidenced By: Community pass with escort only. The CP further revealed a focus of Nursing Communication Etiology: Confusion Additional Detail: Resident has a POTENTIAL for alteration in communication secondary to: Another CP dated 5/30/2025, with no revision date, revealed a focus of Nursing: Disorders of the Brain Etiology: Dementia As Evidenced By: Confusion Additional Detail: Resident exhibits alteration in brain functioning due to: Resident has POTENTIAL for alteration in brain functioning due to: Dementia. The CP did not include the incident on 8/22/2025, where the resident was found wandering on a multi-lane highway and had a syncopal episode.During a telephone interview with the Police Sergeant (SGT) on 8/29/2025 at 11:49 A.M., he stated the police precinct received calls around 4:20 P.M. on 8/22/2025, for an elderly [person] who looked confused and wandering on the shoulder of the highway. When Resident #1 arrived at the police precinct [they] were confused and only knew [their] name and that [they] were coming from work and was on the way home. The SGT stated that the resident looked out of breath. The SGT further revealed he called the facility who were unaware of the resident's departure. The SGT stated Resident #1 then had a loss of consciousness while sitting in a chair speaking to other officers. Then the ambulance was called, and Resident #1 was transferred to the emergency department.During a telephone interview on 8/29/2025 at 12:36 P.M., the Registered Nurse/Nursing Supervisor (RN/NS) stated that he had called the physician that day and obtained an order for Resident #1 to go out on pass, but I forgot to put in the order and write the note. The RN/NS acknowledged it was important to document the order because it made everyone aware that the resident was allowed to go out on pass. During an interview on 9/02/2025 at 2:41 P.M., the DON stated that the nurses initiated CPs on admission and with any incidents to ensure the plan of care was accurate for the resident. At that time, the DON reviewed Resident #1's CP in the presence of the surveyor and acknowledged the resident had an intervention for out on pass with escort only. The DON stated that the Unit Manager should have updated the CP post MDS assessment when the resident's BIMS score changed.A review of the facility's policy titled ACCIDENTS/INCIDENTS INVESTIGATION PROCESS dated 6/05/2025, revealed under PROCESS.Review previous interventions in the care plan, establish new intervention for this specific incident and write it in the incident report and update the care plan.A review of the facility's policy titled COMPREHENSIVE CARE PLAN DATE 6/05/2025, revealed under Policy Statement: C. Each resident's comprehensive care plan shall be reviewed and updated by the interdisciplinary team as per MDS 3.0 schedule: quarterly, annually, significant in condition

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint: 2600629, 2601350Based on interviews, review of medical records, and review of other pertinent facility documentation on 08/29/2025 and 9/02/2025, it was determined that the facility failed to follow acceptable standards of nursing practice by a.) not documenting a physician's order for a resident (Resident #1) to leave the facility on pass (out on pass) and b.) not following a physician's order for a psychiatric consultation and psychological consultation for a resident (Resident #1) that was ordered at admission to the facility.This deficient practice was identified for 1 of 3 sampled residents (Resident #1) and was evidenced by the following: 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 response to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized Physician or dentist. 1. The surveyor reviewed the medical record for Resident #1. According to Resident #1's face sheet, the resident was admitted to the facility with diagnoses that included but was not limited to: vascular dementia with mood disorder (commonly known as memory and thinking problems caused by poor blood flow to the brain along with mood changes). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 08/21/2025, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated the resident had a moderately impaired cognitive status. A review of the Progress Notes (PN) included a Nursing Note dated 8/22/2025 at 7:18 P.M., that the nurse saw Resident #1 around 3:10 P.M., well dressed with a cellphone in hand. At 3:15 P.M., when the nurse returned from the end of the hallway, the resident stated they wanted to sit outside. The nurse said okay, and documented that the physician was informed to get an out on pass order. Unfortunately, [the resident] decided to walk away from the building while out on pass and police found [the resident] away from the building. [The resident] was accompanied by the police to the police precinct. The Director of Nursing (DON) and the writer were contacted. Due to a syncopal (loss of consciousness) episode at the police precinct, [the resident] had to be transferred to the emergency room for evaluation. A review of the physician's orders (PO) on 8/29/2025, did not include a PO for the Resident #1 to go out on pass at the time of the incident. During a telephone interview on 8/29/2025 at 12:36 P.M., the Registered Nurse/Nursing Supervisor (RN/NS) stated that he had called the physician that day and obtained an order for Resident #1 to go out on pass, but I forgot to put in the order and write the note. The RN/NS acknowledged it was important to document the order because it made everyone aware that the resident was allowed to go out on pass. During an interview on 8/29/2025 at 1:14 P.M., with the Licensed Nursing Home Administrator (LNHA) and the DON, the DON stated the RN/NS did not write the order, so I immediately did a one-to-one in-service with the [RN/NS] and other nursing staff. The DON also stated that she called the physician who confirmed that an order was obtained. The DON confirmed the nurse did not document the physician's order for Resident #1 to go out on pass. 2. The surveyor reviewed the medical record for Resident #1. According to Resident #1's face sheet, the resident was admitted to the facility with diagnoses that included but was not limited to: vascular dementia with mood disorder (commonly known as memory and thinking problems caused by poor blood flow to the brain along with mood changes). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 8/21/2025, revealed that Resident #1 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated the resident had a moderately impaired cognitive status. A review of the physician's orders (PO) on 8/29/2025, for Resident #1, included a PO dated 5/30/2025, for a consultation (consult) for a psychiatry evaluation with [name redacted group]. A review of an additional PO dated 5/30/2025, included a psychology consult. A review of the medical record included a psychiatric consult that was completed almost three months later on 8/25/2025, after the resident eloped from the facility. A further review did not include that a psychology consult was obtained as ordered. During an interview on 9/2/2025 at 2:41 P.M., the DON stated that upon admission to the facility, there were certain consultations that were a standard order for all residents, which included the psychiatric and psychological consults. The DON stated the orders should have been for as needed psychiatric and psychological consults. The DON confirmed the PO's were not followed as written for Resident #1; that there was no psychological consult obtained, and the psychiatric consult was done on 8/25/2025. A review of the facility's policy titled Out on pass dated 7/1/2025, revealed under PROCEDURE: 6. Nursing Supervisor will notify