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	05/06/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, interviews, and record review on 5/6/26, it was determined that the facility failed to ensure that a cognitively impaired resident (Resident #1), who required care assistance, was free from verbal abuse by staff. This deficient practice was identified for 1 of 2 residents reviewed for abuse. The deficient practice was evidenced by the following: A review of Resident #1's Face Sheet (FS), an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses, which included but are not limited to, metabolic encephalopathy (a brain dysfunction caused by systemic illness, organ failure, or chemical imbalances in the blood, rather than a direct physical injury to the brain), altered mental status, muscle weakness, cognitive communication deficit, depression, anxiety disorder, and osteoarthritis (a degenerative joint disease where the protective cartilage on the ends of bones wears away over time, causing joint pain, stiffness, and reduced mobility). A review of the resident's care plan activity report (CP) revealed the following: Under Focus, BIMS/Brief Interview for Mental Status, initiated 3/9/26, revealed moderate cognitive impairment BIMS score 0-7. Under Focus, ADLs (Activities of Daily Living), initiated 3/9/26, revealed interventions, included but not limited to, transfer, chair transfer: supervision or touching; support: one person physical assist; modes of transfer: pivot with one person assist. A review of the local police department [name redacted] Incident Report (IR), dated 4/12/26 revealed that Resident #1's family member reported inappropriate comments were made by facility staff to Resident #1. A review of the Reportable Event Record/Report (FRE) dated 4/13/26 revealed the following: The date and time of the event as 4/12/26 at 1:09 PM. The FRE further revealed under Narrative that on Sunday, 4/12/26, Resident #1's family member called police claiming an allegation of abuse. The family member had left their phone on record under the bed since 4/9/26 and was alleging the recording indicated that staff were verbally inappropriate during care on Thursday, 4/9/26, between 7 PM and 8 PM. Staff were suspended pending investigation. CNA #1's statement obtained 4/15/26 via a phone interview revealed that during care, Resident #1 stated No and resisted, but care was continued. CNA #2's statement obtained 4/15/26 via a phone interview revealed that Resident #1 was resisting and that CNA #1 made an inappropriate comment about Resident #1. A facility document titled Report of Investigation (ROI) indicated under 3. Investigation Process. The investigation began immediately with the suspension of the 2 staff who provided care to [Resident #1] on the 3 to 11 pm shift on Thursday 4/9/26. Head to toe assessment was completed, no bruises or redness noted. [.] 6. Conclusion of Investigation. In conclusion, this was verbal abuse/ inappropriate language towards a resident. Resident will be monitored closely for any untoward behavioral changes. Staff involved are, terminated, Staff in-services continue. On 5/6/26 at 1:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA denied there were any grievance filed by Resident #1's family member. The LNHA stated that the audio recording was reviewed and even though CNA #1 denied the allegation we recognized CNA #1's voice making inappropriate comments to Resident #1. The LNHA further stated that CNA #3 stated the incident should have been reported to the supervisor or the nurse. A review of the facility's policy on Abuse Prevention & Reporting with a revised date of 1/28/26 and review date of 4/12/26 revealed under (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: 1. Residents of this center will be protected from abuse, neglect, mistreatment, or misappropriation of property in accordance with State and Federal Regulations. Under Definitions revealed: Verbal Abuse, defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to resident or their families, or within hearing distance regardless of their age, ability to comprehend, or disability. Under Training: 2. Training will include direct teaching regarding: How to report allegations or suspected cases [.]. Under Responsibility and Actions: All licensed employees are responsible to 1. Notify their supervisor immediately. 2. Notify Administration of same. 3. Will complete written statement to aid in investigation. Under Allegation of Abuse, neglect, exploitation or mistreatment and injuries of unknown source: 1. All alleged violations of abuse are to be reported immediately but no later than 2 hours if the alleged violation involve abuse or results in serious bodily injury. N.J.A.C. 8:39-4.1(a)5