

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Adroit Care Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Complaint #: 3131839Based on observation, interview and record review, it was determined that the facility failed to; a.) notify the resident's physician to ensure that there was a physician order to discharge a resident and b.) notify the resident's legal guardian (LG) about discharge planning to ensure sufficient preparation for a safe and orderly discharge from the facility. This deficient practice was identified for 1 of 3 residents, (Resident #2) reviewed for discharge process. The deficient practice was evidenced by the following: A review of the admission Record (AR) revealed that the resident was admitted to the facility with diagnosis which included but not limited to: dementia (decline in mental abilities), essential hypertension (high blood pressure that has no clear, single medical cause), and muscle weakness (lack of physical strength where extra effort is needed to move your arms, legs, or other muscles). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 02/12/2026, revealed a Brief Interview Mental Status (BIMS) score of 14 out of 15, which indicated that the resident was cognitively intact. A review of the hospital Progress Note (PN) dated 02/08/2026, at 4:46 PM, the physician documented: Resident #2 consistently refused subacute rehab, home health, and outpatient services, and was ultimately found to lack medical decision-making capacity on repeated psychiatric evaluation, prompting initiation of guardianship proceedings for discharge planning. By 02/05/2026, temporary guardianship was established and Resident #2 was discharged to a subacute rehabilitation facility. A review of the nursing PN dated 02/10/2026, at 11:19 AM, the Licensed Practical Nurse (LPN #1) documented: Resident #2 refused vital sign readings and medication despite education and encouragement x2 [twice], the Medical Doctor (MD) and legal guardian (LG) made aware. No new orders at this time. A review of the nursing PN dated 02/17/2026, at 1:59 PM, LPN #1 documented: Resident #2 refused vital sign readings and medication despite education and encouragement x2, MD and LG made aware. No new orders at this time. A review of the nursing PN dated 02/23/2026, at 2:54 PM, LPN #1 documented: Resident #2 refused vital sign readings and medication despite education and encouragement x2, MD and LG made aware. No new orders at this time. A review of the nursing PN dated 02/25/2026, at 2:58 PM, LPN #1 documented: Resident #2 discharged at 11:45 AM in stable condition. During an interview on 07/31/2026 at 10:21AM, the Unit Manager (UM)/LPN #1 stated, the MD should be notified by the nurse and social worker of a discharge. There should be a doctor's order for all discharges. The UM/LPN #1 further stated, the resident's responsible party should be notified of the discharge plans prior to discharge. During an interview on 07/31/2026 at 11:27AM, the Director of Social Work (DSW) stated, For all residents with a responsible party and LG, I have to reach out to them concerning discharge planning. He further stated, I did not reach out to Resident #2's LG, I should have reached out. I did not look at the paperwork correctly to see that Resident #2 had a LG listed. During an interview on 07/31/2026 at 12:21 PM, the Director of Nursing (DON), in the presence of the Licensed Nursing Home (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator (LNHA), stated the resident's physician should be notified by the nurse and obtain a discharge order. The nurse should also notify the resident's responsible party or LG about discharge planning. The DON further stated, for Resident #2, there was no discharge order or notification to the LG about the discharge. The DON acknowledged the facility's discharge policy was not followed for Resident #2. On 07/31/2026 at 10:30 A.M., the surveyor attempted to conduct a phone interview with LPN #1, however; LPN #1 could not be reached for the interview. A review of the facility's policy titled: Discharge Policies and Procedures dated 02/20/2017, revealed under Policy: residents shall be discharged from the facility only in accordance with a physician's order and in compliance with all applicable federal, state and local regulations. Under Purpose revealed: the purpose of this policy is to ensure that residents are discharged safely from the facility with appropriate planning, continuity of care, and necessary arrangements to support the resident's ongoing health and well-being. Under Physician's Order revealed: the resident's attending physician must issue a written and signed discharged order. The order shall include, when applicable, medication instructions and disposal instructions. Under Discharge Procedure revealed: 1. Explain the discharge process to the resident and family or the responsible party. NJAC 8:39-4.1; 27.1 (a)		