STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315321	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Old Bridge, LLC	6989 Rt18 Old Bridge, NJ 08857

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 0656 Level of Harm - Minimal harm or potential for 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. Complaint#: NJ187513, NJ187972Based on interviews, closed medical record review, and review of other pertinent facility documents on 7/10/2025, it was determined that the facility failed to develop an elopement risk care plan (CP) for a resident (Resident #5) who was identified as an elopement risk. This deficient practice was identified in 1 of 4 residents reviewed for elopement risk. This deficient practice was evidenced by the following:The surveyor reviewed the closed medical record for Resident #5.According to the admission Record (AR), Resident #5 was admitted to the facility with diagnoses which included but were not limited to Diabetes, Anemia, Hyperlipidemia (high cholesterol). A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/11/2025, Resident #5 had a Brief Interview of Mental Status (BIMS) score of 12 out of 15, which indicated the resident had moderate cognitive impairment. A review of Resident #5's Elopement Risk Evaluation form dated 6/20/2025 revealed Resident #2 was at risk for elopement.A review of Resident #5's Care Plans (CP) revealed no elopement risk care plan for Resident #5.During an interview on 7/10/2025 at 3:30 PM with the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), the DON stated that if a resident was an elopement risk they should have a care plan in place. The DON further indicated that it was important for nursing staff to update the care plan so that all staff know how to care for the resident. The DON confirmed that there was no elopement risk care plan for Resident #5. The DON stated that the nursing staff had 14 days to update the resident's care plan according to the facility policy. The DON further stated the resident was discharged prior to the 14-day period the staff had to update the care plan. A review of the facility's policy titled Care Plan Revisions Upon Status Change revised on 3/2025 revealed under Policy Explanation and Compliance Guidelines, 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: d. The care plan will be updated with the new or modified interventions within 14 days.NJAC 8:39-27.1 (a)

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
	315321	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Old Bridge, LLC	6989 Rt18 Old Bridge, NJ 08857

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews, medical record review, and review of other pertinent facility documentation on 7/10/2025 it was determined that the facility failed to follow their protocol and policy to prevent the elopement of a safety awareness impaired resident (Resident #2) who exited the facility from the rear entrance when an incoming family member entered the facility and held the door for Resident #2 to leave the facility and return to their home with staff failing to adequately supervise resident and ensure safety of its residents. This REQUIREMENT is NOT MET as evidenced by:Complaint#: NJ187513, NJ187972Based on interviews, medical record review, and review of other pertinent facility documents on 7/10/2025, it was determined that the facility failed to follow their protocol and policy to prevent the elopement of a safety awareness impaired resident (Resident #2) who exited the facility from the rear entrance when an incoming family member entered the facility and held the door for Resident #2 to leave the facility and return to their home with staff failing to adequately supervise resident and ensure safety of its residents. This deficient practice was evidenced by the following:According to the admission Record (AR) Resident #2 was admitted to the facility with diagnoses which included but were not limited to: hypertension, altered mental status and vascular dementia.A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/28/25. Resident #2 had a Brief Interview of Mental Status (BIMS) score of 4 out of 15, which indicated the resident had moderate cognitive impairment.According to the facility reportable event (FRE) dated 6/17/2025, the FRE indicated that on 6/16/2025, Resident #2 was able to tell facility staff member that at approximately 6:30 PM resident chose to go home and arranged his/her own transportation. At approximately 7:15 PM facility staff received a phone call from the resident family member, asking why resident had gone home. The surveyor reviewed Resident #2's nurses (NN) dated 6/17/25 at 12:57 PM. The NN revealed that writer last checked Resident #2 around 6:00 PM in his/her room sitting in a chair. Around 7:15 PM, a call was received from family member stating can you explain to me how my (resident) got home when he/she is supposed to be at your facility. Writer went to resident room and resident was not there. All resident rooms were checked on the unit, resident was not located. On 7/10/2025 at 11:15 AM, the surveyor interviewed RN #1 who stated around 5 PM when she went into the room to give Resident #2's roommate medication, she saw Resident #2 sitting in a chair. RN #1 left the room to perform other duties and returned to resident room around 6 PM to check his/her blood pressure. Resident was observed to be sitting in same chair. RN #1 left the room to return to the nurses desk. At around 7:15 PM the phone rang with resident family member was on the phone asking how he/she got home. On 7/7/2025 at 2:25 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Administrator. The DON stated that Resident #2 had no key to get into his/her home. He/she went to the neighbor next door to get the spare key. Afterwards, the neighbor called the family member to alert them that resident had asked for the key to get in and was at home. A review of the facility's policy titled Elopement Prevention and Management revised 10/24 revealed under Policy: The facility defines elopement as follows:, When a cognitively impaired resident/patient leaves the facility grounds unattended and without staff knowledge.NJAC 8:39-33.1(d)