STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315522	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accelerate Skilled Nursing and Rehab Piscataway	10 Sterling Drive Piscataway, NJ 08854

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. Based on record review, interview, and review of facility policy, the facility failed to ensure that medical records were provided to residents or their legal representatives in a timely manner. This deficient practice was identified for three of six sampled residents (R)13, (R)15, and (R)16 which delayed access to essential health information. Review of the facility's policy titled Authorization for Release of Information dated 05/01/22 revealed that access to view documents must be provided within 24 hours of receipt of a request, and copies of records must be provided within two working days. 1.Review of R13's diagnosis sheet provided by the facility revealed an admission date of 05/20 and discharge date in 06/20. Review of correspondence from the New Jersey Department of Health (NJDHS) dated 04/23/25 revealed R13's legal representative made multiple medical record requests on 09/20/24, 11/08/24, and 08/13/24. During an interview on 08/04/25 at 11:30 AM with the Administrator revealed as of 02/25, all medical record requests for residents cared for under the previous facility are to be made or forwarded to Paralegal (PL)2 and this may be the cause of why requests are delayed. During an interview with (PL)1 on 08/08/25 confirmed receipt of R13's medical records from April 2024, but records for the following dates 09/20/24, 11/08/24, and 08/13/24 had not been received. 2.Review of R15's Face Sheet located in the electronic medical record (EMR) revealed an admission date of 07/24 and discharge date of 01/24. Review of a detailed timeline provided by R15's family member revealed she submitted a medical records request in person on 04/08/25 and sent a certified request on 05/27/25 addressed to the Administrator. During an interview with R15's family member on 08/08/25, she confirmed she had not received the requested records. 3.Review of R16's diagnosis sheet provided by the facility revealed an admission date of 04/24 and discharge in 05/24. Review of NJDHS correspondence dated 03/14/25 revealed multiple record requests on 09/06/24, 10/13/24, and 11/15/24. Review of email correspondence provided by the facility showed the requests remained unfulfilled until 07/25/25. During an interview with PL3 on 08/08/25 at 11:32AM the PL3 revealed they followed up with the facility on 07/23/35 expressing that R16's request was not fulfilled. She confirmed she did receive the records finally on 07/25/25.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and review of facility policy, the facility failed to provide care and treatment in a timely manner for an unavoidable pressure ulcer for one of three residents (Resident (R) 5) reviewed for pressure ulcers out of a total sample of 20. The wound was not properly assessed for seven days. This resulted in harm when the wound was determined to be an unstageable pressure ulcer that resulted in hospitalization for the resident with a diagnosis of sepsis, with the pressure ulcer being the possible source of the sepsis.Review of the facility's policy titled, Pressure Injury Prevention Guidelines, dated 03/04/25, revealed, . to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present . The effectiveness of interventions will be monitored through ongoing assessment of the resident and/or wound . Review of R5's Face Sheet, located in the Profile tab of the electronic medical record (EMR), revealed R5 was admitted to the facility on 01/25 with diagnoses that included pressure ulcer of sacral region stage II, malignant neoplasm of unspecified part of the right bronchus or lung, secondary malignant neoplasm of mediastinum, chronic obstructive pulmonary disease, chronic viral hepatitis C, hepatomegaly, and polyneuropathy. Review of R5's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/25 and located in the resident's EMR under the MDS tab, revealed R5 had a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated R5's cognition was intact for decision-making. It was recorded R5 required partial to moderate assistance with bed mobility, was occasionally incontinent of bladder and bowel, and had one stage 2 pressure ulcer. It was recorded pressure reducing devices were in use for the resident's chair and bed, a turning program was in place, and nutritional interventions were implemented. Review of R5's Initial Wound Assessment, located in the EMR under the Assessment tab and dated 01/17/25, revealed R5 was seen by the Wound Care Nurse (WCN) for an initial evaluation of a stage II sacral pressure sore. It was recorded, . Initial wound encounter measurements are 0.5cm length x 0.4cm width x 0.1 cm depth, with an area of 0.2 sq cm and a volume of 0. 02 cubic cm. There is a Moderate [sic] amount of sero-sanguineous drainage noted which has no odor . Review of R5's Physician Order, dated 01/17/25 and located under the Orders tab of the EMR, revealed an order to cleanse R5's pressure ulcer with wound cleanser and to apply Calazime Skin Protectant to the sacrum once daily. It was also ordered for the resident to have weekly skin assessments on Mondays. Review of R5's Care Plan, dated 01/17/25 and located under the Care Plan tab of the EMR, revealed R5 had a documented pressure ulcer. Interventions included to evaluate ulcer characteristics and monitor ulcer for signs of progression or declination. Review of R5's Physician Orders, dated 01/30/25 and located under the Orders tab of the EMR, revealed an order for Phytoplex Z-Guard Paste to R5's sacrum twice daily for IAD (incontinence associated dermatitis). Review of R5's Progress Note, dated 01/31/25, located under the Progress Notes tab of the EMR, and written by the WCN, indicated the stage II sacral pressure ulcer was healed/resolved. It was recorded there was no slough or eschar present, there were no signs or symptoms of infection, and there was 100% epithelialization. Review of R5's eMAR PN (electronic Progress Note), dated 02/10/25 at 9:05 PM and located under the Progress Notes tab of the EMR, revealed, . Weekly skin assessment: Monday one time a day every Mon No new skin issues noted . Review of R5's eMAR PN, dated 02/14/25 at 2:41 PM and located under the Progress Notes tab of the EMR, revealed, . Phytoplex A-Guard . wound care completed as per current order and wound nurse on rounds today and patient has wound care consult and asked wound nurse to see . Review of R5's Progress Notes tab revealed no documented evidence of why the WCN was asked to see R5. There was no other documented evidence related to R5's skin integrity at this time, including if R5's sacral pressure ulcer had reopened or that R5 had developed a new pressure ulcer. There was no documented evidence R5 still had IAD. Review of R5's Orders and Progress Notes tabs of the EMR and review of the WCN's consolidated Progress Note Details revealed no documented evidence R5 was seen by the WCN on 02/14/25. Review of R5's Progress Note, dated 02/17/25 at 11:55 AM and located under the Progress Notes tab of the EMR, revealed, . Pt [patient] picked up by family for his appointment . Wound care completed prior to leaving . Review of the TAR, dated 02/17/25 at 9:00 AM, revealed R5 received Phytoplex Paste to the sacrum. Review of R5's entire EMR revealed no further information related to R5's skin integrity. There was no documentation to show if R5's pressure ulcer had reopened or if a new pressure ulcer had developed. There was no documented evidence R5 still had IAD. Review of R5's Progress Notes tab of the EMR for 02/18/25 revealed no documented evidence related