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	11/10/2025

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of pertinent facility documents on 11/05/25, 11/06/25, and 11/10/25, it was determined that the facility failed to ensure a cognitively impaired resident (Resident #1) was protected from neglect when the resident was found unresponsive outside on the patio during a heat wave and was sent to the emergency room for heat stroke (life-threatening from environmental heat exposure). This deficient practice was identified for 1 of 4 residents reviewed for abuse and neglect (Resident #1).On 07/29/25 at 11:15 AM, Resident #1's Representative (RR #1), a companion, discovered Resident #1 outside on the second-floor patio unresponsive. RR #1 immediately informed the Registered Nurse (RN #1), who went outside and found the resident unconscious. Resident #1 was brought inside to their room, and RN #1 performed a sternal rub (rubbing the chest area) which the resident became alert, but drowsy with a temperature of 103.8 degrees Fahrenheit (F) (normal range 97.7 to 99.0 degrees F) and a heart rate (HR) of 124 beats per minute (bpm) (normal range 60-100 bpm). Resident #1 received treatment of an ice pack and Tylenol and was sent to the emergency room (ER). The resident remained in the ER for twenty-four hours being treated for heat stroke. The facility's failure to protect a cognitively impaired resident by ensuring staff provided residents supervision and oversight, placed Resident #1 as well as all residents at risk for neglect. This posed the likelihood of serious physical harm, injury, or death which resulted in an immediate jeopardy (IJ) situation.The IJ began on 07/29/25, at approximately 11:15 AM, when Resident #1 was found unresponsive outside on the patio in extremely hot weather. The facility's Administration was notified of the IJ on 11/10/25 at 2:43 PM. The facility submitted an acceptable Removal Plan (RP) on 11/13/25 at 4:52 PM. The surveyor verified the implementation of the Removal Plan on-site during the continuation of the survey 11/17/25. The deficient practice was evidenced as follows:A review of the facility's Abuse, Neglect, Exploitation and Misappropriation Prevention policy dated 06/18/25, included Policy: Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.Interpretation and Implementation: The resident abuse, neglect, and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone; 2. Develop and implement policies and protocols to prevent and identify:.b. neglect of residents;.8. Identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property.A review of the facility's Extreme Heat Policy dated implemented 07/29/25, included it is the policy of the facility to maintain a safe, comfortable, and temperature-controlled environment. In periods of extreme heat, staff must take all necessary actions to prevent heat-related illness, dehydration, or other complications among resident and staff. Definitions: 1. Extreme heat: ambient indoor or outdoor temperatures that exceed 80 degrees F and/or the heat index or local heat advisory indicates hazardous conditions. 2. Heat related illness: includes heat exhaustion, heat cramps, or heat stroke caused by prolong exposure to high temperatures.The surveyor reviewed the medical record for Resident #1.A review of the admission Record (AR) face sheet (an admission summary), revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to; multiple sclerosis (an autoimmune disorder between the brain and the body leading to symptoms such weakness, numbness, coordination problems, and vision issues), encephalopathy (a condition that affects the brain's function resulting in altered mental state), muscle weakness, atherosclerotic heart disease (heart disorder), dementia, repeated falls, and personal history of transient ischemic attack (TIA) and cerebral infarction (stroke).A review of the Minimum Data Set (MDS), an assessment tool dated 09/30/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which reflected a severely impaired cognition. The MDS further revealed that the resident required assistance from staff in the completion of their activities of daily living (ADLs).A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 06/30/22, that the resident required assistance/potential to restore function for mobility as evidenced by limited mobility related to inability to move independently. Interventions included but were not limited to; one person assistance with ambulation.A review of the Resident #1's Progress Notes included a nurse's note documented by RN #1 on 07/29/25 at 11:20AM, that the resident was seen sitting on the patio and this writer was going to do vital sign checks when they were called by RR #1 to check on the resident. The resident was initially drowsy, responded to verbal stimuli, and become unconscious with breathing present. Vital signs were taken: blood pressure 123 millimeters of mercury (mmHg) over 78 mmHg (123/78)

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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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and review of pertinent facility documents on 11/05/25, 11/06/25, and 11/10/25, it was determined that the facility failed to report within two hours to the New Jersey Department of Health (NJDOH) an allegation of neglect that occurred on 07/29/25. This deficient practice was identified for 1 of 4 residents reviewed for abuse and neglect (Resident #1), and was evidenced by the following:The surveyor reviewed the medical record for Resident #1. A review of the admission Record (AR) face sheet (an admission summary), revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to; multiple sclerosis (an autoimmune disorder between the brain and the body leading to symptoms such weakness, numbness, coordination problems, and vision issues), encephalopathy (a condition that affects the brain's function resulting in altered mental state), muscle weakness, atherosclerotic heart disease (heart disorder), dementia, repeated falls, and personal history of transient ischemic attack (TIA) and cerebral infarction (stroke). A review of the Minimum Data Set (MDS), an assessment tool dated 09/30/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which reflected a severely impaired cognition. The MDS further revealed that the resident required assistance from staff in the completion of their activities of daily living (ADLs). A review of the Resident #1's Progress Notes included a nurse's note documented by RN #1 on 07/29/25 at 11:20AM, that the resident was seen sitting on the patio and this writer was going to do vital sign checks when they were called by RR #1 to check on the resident. The resident was initially drowsy, responded to verbal stimuli, and become unconscious with breathing present. Vital signs were taken; blood pressure 123 millimeters of mercury (mmHg) over 78 mmHg (123/78), HR 124 bpm, unlabored breathing 18 breaths per minute, temperature 103.8 degrees F, oxygen saturation 97% on room air, and blood sugar 94. The resident was assisted back to room in cool environment, ice pack was applied, the resident responded to sternum rub and regained consciousness. The resident denied pain or distress. Supplemental oxygen and cool sponge were provided, and Tylenol was administered. The physician was notified and ordered the resident transferred out to ER for further evaluation. A review of the facility's investigation report dated 07/31/25, included the following: Incident: On 7/29/25 at approximately 11:15 AM, [RN #1] noted [RR #1] was trying to get [the resident] up in the patio. [The resident] was observed drowsy but responded to verbal stimuli. Vital signs were checked, and the resident's temperature was 103.8 degrees F and heart rate was 124 bpm. The resident was immediately assisted back to their bed via wheelchair, and the resident became more alert and verbally responsive. Cooling measures were applied, and the resident was given Tylenol at 11:50 AM. The physician was notified and ordered to transfer the resident to the hospital. Resident #1's Representative (RR #2) was notified, and they agreed to the hospital transfer. Investigation: that per interview with staff, RN #1 on 07/29/25, at approximately 10:00 AM, noticed that the Certified Nursing Assistant (CNA #1) was still providing care on Resident #1, and she proceeded to give morning medications to another resident. Per CNA #1, after he provided care to Resident #1, he walked them out of their room, and another CNA (CNA #2) took the resident to the dayroom. CNA #1 stated he noted that the resident was in the dayroom at around 11:00 AM, during his dayroom assignment to watch the residents, but he did not realize if the resident's private companion (RR #1) brought the resident out of the dayroom to the patio when RR #1 arrived. RR #1 arrived at the facility at 11:03 AM. At approximately 11:15 AM, RN #1 noted the resident was at the patio with RR #1 trying to get the resident up. Resident #1 was observed sitting on the couch with some shade, drowsy but responded to verbal stimuli. Resident #1 was assisted back to their room via a wheelchair. Vital signs were checked and noted with elevated temperature and heart rate. Cooling measures were provided, and Tylenol was given. Vital signs were rechecked: blood pressure-119/70, HR-104 bpm, breathing 18 breaths per minute, oxygen saturation on room air-96%, temperature- 97.1 degrees F, and resident was back to their baseline. The physician was informed and ordered the resident to be sent to the hospital to rule/out seizure. Other CNAs that worked that day were interviewed, but no one noticed Resident #1 going out to the patio by themself. They also stated, Resident #1's family did not want the resident out to patio unless with the companion (RR #1). Transport [name redacted] was called and the resident was picked up at 1:15 PM. They left for the hospital with no signs of distress. Resident #1 was sent to hospital [name redacted]. A review of emergency room (ER) paperwork dated 07/29/25 at 1:50 PM, included history of present illness that Resident #1 arrived at the ER by emergency medical services (EMS) for an episode of unresponsiveness. Per [Resident #1's sending facility name redacted], [Resident #1] was outside 30-40 minutes sitting on a

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interviews and review of pertinent facility documents on 11/05/25, 11/06/25, and 11/10/25, it was determined that the facility failed to thoroughly investigate an incident of resident heat stroke (life-threatening from environmental heat exposure) to rule out neglect. This deficient practice was identified for 1 of 4 residents reviewed for abuse and neglect (Resident #1), and was evidenced by the following:The surveyor reviewed the medical record for Resident #1. A review of the admission Record (AR) face sheet (an admission summary), revealed that Resident #1 was admitted to the facility with diagnoses which included but were not limited to; multiple sclerosis (an autoimmune disorder between the brain and the body leading to symptoms such weakness, numbness, coordination problems, and vision issues), encephalopathy (a condition that affects the brain's function resulting in altered mental state), muscle weakness, atherosclerotic heart disease (heart disorder), dementia, repeated falls, and personal history of transient ischemic attack (TIA) and cerebral infarction (stroke). A review of the Minimum Data Set (MDS), an assessment tool dated 09/30/25, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which reflected a severely impaired cognition. The MDS further revealed that the resident required assistance from staff in the completion of their activities of daily living (ADLs). A review of the resident's individual comprehensive care plan (ICCP) included a focus area dated 06/30/22, that the resident required assistance/potential to restore function for mobility as evidenced by limited mobility related to inability to move independently. Interventions included but were not limited to; one person assistance with ambulation. A review of the Resident #1's Progress Notes included a nurse's note documented by RN #1 on 07/29/25 at 11:20AM, that the resident was seen sitting on the patio and this writer was going to do vital sign checks when they were called by RR #1 to check on the resident. The resident was initially drowsy, responded to verbal stimuli, and become unconscious with breathing present. Vital signs were taken; blood pressure 123 millimeters of mercury (mmHg) over 78 mmHg (123/78), HR 124 bpm, unlabored breathing 18 breaths per minute, temperature 103.8 degrees F, oxygen saturation 97% on room air, and blood sugar 94. 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Resident #1 was observed sitting on the couch with some shade, drowsy but responded to verbal stimuli. Resident #1 was assisted back to their room via a wheelchair. Vital signs were checked and noted with elevated temperature and heart rate. Cooling measures were provided, and Tylenol was given. Vital signs were rechecked: blood pressure-119/70, HR-104 bpm, breathing 18 breaths per minute, oxygen saturation on room air-96%, temperature- 97.1 degrees F, and resident was back to their baseline. The physician was informed and ordered the resident to be sent to the hospital to rule/out seizure. Other CNAs that worked that day were interviewed, but no one noticed Resident #1 going out to the patio by themself. They also stated, Resident #1's family did not want the resident out to patio unless with the companion (RR #1). Transport [name redacted] was called and the resident was picked up at 1:15 PM. They left for the hospital with no signs of distress. Resident #1 was sent to hospital [name redacted]. The