

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315146</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2020</b>	
NAME OF PROVIDER OR SUPPLIER  <b>CARE CONNECTION RAHWAY</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>865 STONE STREET</b> <b>RAHWAY, NJ 07065</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS			K 000			
	LIFE SAFETY CODE 101: 2012						
	THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE 101: 2012.						
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101			K 351			11/17/20
	Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/20/2020, it was determined that the facility failed to provide automatic fire sprinkler protection to all areas in accordance with NFPA 13. This deficient practice was evidenced by the following:				1. The missing sprinkler was installed on 11/16/2020. 2. All residents have the potential to be affected. 3. Maintenance and facility management will conduct rounds to all areas of the care connection Rahway facility to ensure		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/31/2020

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/01/2022  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315146</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/20/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARE CONNECTION RAHWAY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>865 STONE STREET</b> <b>RAHWAY, NJ 07065</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 351	Continued From page 1 1. At 10:29 a.m., the surveyor, along with the facility Administrator and Director of Plant Operations (DPO), observed that there was no fire sprinkler protection inside the 5 foot by 7 feet 10 inch shower room across from resident room #433.  At that time, the surveyor pointed inside the shower room and said to the DPO, "You need to have a fire sprinkler in here." The DPO looked around and up at the ceiling and replied, Yes I agree.  NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	all areas needing a sprinkler have them. 4. visual inspection to check for sprinklers in place will be added to weekly environmental rounding checklist, to be completed by the Administrator or designee weekly for 3 months. Results will be reported to Quality Assurance Performance Improvement Committee which meets quarterly.		

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315146	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	DATE OF REVISIT 11/20/2020
NAME OF FACILITY CARE CONNECTION RAHWAY	STREET ADDRESS, CITY, STATE, ZIP CODE 865 STONE STREET RAHWAY, NJ 07065	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # NFPA 101	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC K0351	11/17/2020	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
ID Prefix _____	Correction _____	ID Prefix _____	Correction _____	ID Prefix _____	Correction _____
Reg. # _____	Completed _____	Reg. # _____	Completed _____	Reg. # _____	Completed _____
LSC _____	_____	LSC _____	_____	LSC _____	_____
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/20/2020		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			