STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	**865 STONE STREET RAHWAY, NJ 07065**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. There was no deficiency related to the intake # NJ169209 Survey Date : 08/20/2024- 08/23/2024 Census : 21 Sample Size: 12 Supplemental Residents:4 CR's	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of records, and review of pertinent documents, it was determined that the facility failed to provide appropriate NJ Ex Order 26.4(b)(1) for 1 of 2 residents reviewed for Activities of Daily Living (Resident #75 who required [redacted] from staff for care. The deficient practice was evidenced by	F 677	On 8/20/2024, upon observing Resident #75 at 9:00 AM wearing NJ Ex Order 26.4(b)(1), the U.S. FOIA (b) (6) NJ Ex Order 26.4(b) the Resident and placed NJ Ex Order 26.4(b)(1) on the Resident. The U.S. FOIA (b) (6) removed the NJ Ex Order 26.4(b)(1) and placed a NJ Ex Order 26.4(b)(1) on the bed.	9/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	865 STONE STREET RAHWAY, NJ 07065

(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
F 677	Continued From page 1 the following: On 08/20/24 around 8:45 AM, the surveyor toured the [NJ Exec Order 26.4(b)] of the facility. At 8:49 AM, while touring the unit, a NJ Ex Order 26.4(b)(1) of [NJ Ex Order] was permeated in the hallway next to Resident #75's room. The surveyor observed a U.S. FOIA (b) (6)) exited the room. Resident #75 was in the bed fully covered. Resident #75 [NJ Ex Order 26.4(b)(1)] to the surveyor's greetings and NJ Ex Order 26.4(b)(1). The surveyor asked the resident how was life here at the facility, Resident #75 did not answered. The surveyor met the [U.S. FOIA] in the next hallway and summoned her to the room. The surveyor informed the [U.S. FOIA] that she would like to perform a care tour. The [U.S. FOIA] entered the room, checked Resident #75 for [NJ Ex Order 26.4(b)(1)] Resident #75 was [NJ Ex Order] with [NJ Ex Orde] and [NJ Ex Order] The surveyor and the [U.S. FOIA] we both observed that Resident #75 had [NJ] on which were NJ Ex Order 26.4(b)(1) Resident #75 had a [NJ Ex Order 26.4(b] to the [NJ Ex Order 26.4(b)(1)] that was [NJ Ex Order 26.4(b)(] with [NJ Ex Orde] and [NJ Ex Order 26] . The [NJ Ex Order 26.4(b)(1)] were [NJ Ex Order 26.4(b)(] with [NJ Ex Order] the The [U.S. FOIA] informed the surveyor that she reported to work at 7:00 AM this morning, she got report from the nurse and did not receive report from the [U.S. FOIA] who worked from the 7:00 PM-7:00 AM shift. The [U.S. FOIA] added that she had not provided care yet to Resident #75. The surveyor asked the [U.S. FOIA] to call the US FOIA (b)(6) . At 8:55 AM, the US FOIA (b)(6) entered the room and verified that Resident #75 had [NJ Ex Order 26.4(b)(1)] on which were NJ Ex Order 26.4(b)(1). The [NJ Ex Orde] used to [NJ Ex Order 26] the bed were all [NJ Ex Order 26.4(b)(] . The surveyor then interviewed the US FOIA (b)(6) who stated that all residents were to have [NJ Ex Order 26.4(b)(1)]. When asked how the staff will	F 677	The U.S. FOIA (b) (6) changed the [NJ Ex Order 26.4(b)] to the [NJ Ex Order 26.4(b)(1)] . All Residents have the potential to be affected by the placement of two briefs. All staff, including the identified U.S. FOIA (b) (6) who placed [NJ Ex Order 26.4(b)(] on Resident #75, were in-serviced by the Director of Nursing regarding incontinence care and to never to place two briefs on any Resident. Registered Nurses and Licensed Practical Nurses will round to ensure staff is following proper incontinence care and using only one brief on all incontinent Residents. Rounding will occur daily for all incontinent residents for two weeks, then three times per week on all shifts for two weeks. Following that, audit will be conducted 3 times per month with a minimum sample of 10 residents. Findings during rounding will be communicated to the Director of Nursing or designee. Director of Nursing will report on these audits to the facility's quarterly Quality Assurance and Performance Improvement for the next six months. Completion Date: 9/10/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	865 STONE STREET RAHWAY, NJ 07065

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F 677		F 677		

Continued From page 2

know, the US FOIA (b)(6) replied, "The staff had been educated."
On 08/21/24 at 10:30 AM, the surveyor reviewed Resident #75's electronic medical record. The Admission Face Sheet (an admission summary) reflected that Resident #75 was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4

The Admission Minimum Set (MDS) dated NJ Ex Order 26.4(b), reflected that Resident #75 received a score of NJ Ex on the Brief Interview for Mental Status (BIMS) indicative of NJ Ex Order 26.4(b)(1). However interview with staff revealed that Resident #75 was NJ Ex Order 26.4(b)(1) Review of Resident #75's plan of care revealed a focus for NJ Ex Order 26.4(b)(1) in Activities of daily living NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) due to recent hospitalization, initiated NJ Ex Order 26.4(b). The goal was for Resident #75 will improve current level of function in NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) also initiated NJ Ex Order 26.4(b). Resident #75 had also a focus for NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1), initiated NJ Ex Order 26.4(b). The goal was for Resident #75 to decrease frequency of NJ Ex Order 26.4(b)(1) through the next review date of NJ Ex Order 26.4(b). The interventions included, uses NJ Ex Order 26.4(b)(1). NJ Ex Order 26.4(b)(1) and as needed.

An intervention added on NJ Ex Order 26.4, was that Resident #75 prefers using NJ Ex Order 26.4(b)(1) to NJ Ex Ord and keep NJ Ex Order 26.4(b)(1). According to the care plan history, the U.S. FOIA (b) (6) added this intervention on NJ Exec Order 26 after the U.S. FOIA (b) (6)

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	315146	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	865 STONE STREET RAHWAY, NJ 07065

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F 677	Continued From page 3	F 677		

verified with the surveyor that Resident #75 had [NJ] on which were NJ Ex Order 26.4(b)(1). On 08/21/24 at 09:34 AM, the surveyor interviewed the [U.S. FOIA] who cared for Resident #75 on 8/20/24. The [U.S. FOIA] stated that Resident #75 can NJ Ex Order 26.4(b)(1), can NJ Ex Order 26.4(b)(1) and sometimes was [NJ Ex Order 2] of their [NJ Ex Order 26.4(b)(1)] . The [U.S. FOIA] stated that the [U.S. FOIA] who provided care to the resident from 11:00 PM- 7:00 AM shift left the resident with the [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA] added that she got report from the nurse regarding the resident. The [U.S. FOIA] stated that on the morning of [NJ Exec Order 2] she served and set the breakfast tray for Resident #75 and did not checked Resident #75 for [NJ Ex Order 26.4(b)(1)] prior to breakfast. The [U.S. FOIA] added that she was not familiar with Resident #75's routine. The [U.S. FOIA] stated that she did not get report from the [U.S. FOIA] who worked the night shift and was not aware of the time that NJ Ex Order 26.4(b)(1) was last provided.

On 08/21/24 at 10:30 AM, the surveyor again interviewed the U.S. FOIA (b) (6)) who was in the room with the [U.S. FOIA] and witnessed Resident #75 with the NJ Ex Order 26.4(b)(1). The [U.S. FO] stated that Resident #75 should not have [NJ Ex Order 26] .

On 08/22/24 at 12:50 PM, the above concerns were discussed with the [U.S. FOIA] in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6). The surveyor asked the [U.S. FOIA] regarding her expectations regarding NJ Ex Order 26.4(b)(1). In the presence of the survey team, the [U.S. FOIA] stated that residents were to have one NJ Ex Order 26.4(b)(1). The [U.S. FOIA] further added, that "[NJ Ex Order 26.4(b)(1)]" at times would have [NJ] on when requested The [U.S. FOIA] added that Resident #75 would not allowed staff to provide NJ Ex Order 26.4(b)(1) while

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	315146	A. BUILDING _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 677	Continued From page 4	F 677		

playing cards. The surveyor informed the U.S. FOIA that in the morning of 8/20/24 at 8:40 AM, Resident #75 was in bed fully covered. The U.S. FOIA admitted that she set up the breakfast tray and did not checked Resident #75 prior to breakfast. According to staff breakfast was served around 7:30 AM-7:45 AM on 8/20/24.

Resident #75 assessed by the facility as having NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(or NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1) on staff for all activities of daily living. During the survey, the surveyor attempted to interview Resident #75 on 8/20/24 at 8:35 AM and again on 8/21/24 at 10:30 AM, Resident #75 was NJ Ex Order 26.4(b)(with the interview.

On 08/23/24 at 11:52 AM, the NJ Ex Ord who worked the 7:00 PM-7:00 AM shift, returned the call. The NJ Ex Ord informed the surveyor that she did not provide care to the resident in the morning. The US FOIA (stated that another NJ Ex Ord who worked the 3:00 PM- 11:00 PM cared for Resident #75 and placed the NJ Ex Order 26.4(b)(1) the resident around 12:00 PM. The U.S. FOIA stated on 8/20/24 around 4:00 AM when she went to the room Resident #75 was NJ Ex Order 26.4(and did not want to be NJ Ex Order 26.4(for NJ Ex Order 26.4(b)(1). She did not return to the room nor inform the nurse that Resident #75 was not cared for during the shift. According to the interview with the U.S. FOIA, almost 9 hours had elapsed since Resident #75 was provided with NJ Ex Order 26.4(b)(1).

The surveyor then asked the U.S. FOIA how often that she would observed other residents who were NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4 on. The U.S. FOIA stated the residents that were NJ Ex Order 26.4(b)(1) would have NJ Ex O . The NJ Ex Order 26.4(b will be placed inside

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CARE CONNECTION RAHWAY	**865 STONE STREET RAHWAY, NJ 07065**

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F 677	Continued From page 5 the NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) and would not be snapped. When asked if she reported the concerns to the nurses or the U.S. FOIA she stated, "No". . A review of the policy for Activities of Daily Living last revised 1/2024, provided by the facility on 8/21/24 indicated the following:" Residents shall receive assistance with activities of daily living (ADLs) every shift, as appropriate." The facility's policy for incontinence care indicated that the facility shall provide care for all incontinent residents. NJAC 8:39-27.1(a),	F 677		

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	12006L	A. BUILDING: _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	865 STONE STREET RAHWAY, NJ 07065

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift and evening shift as mandated by the State of New Jersey. The facility was deficient in CNA (Certified Nursing Aide) staffing for the following weeks as follows: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	The facility assigned one additional Certified Nurse Aide during evening shift to meet the Staffing Requirement that half of all staff members shall be Certified Nurse Aides. All Residents have the potential to be affected by this. Staffing Coordinator was in-serviced by the Director of Nursing on the requirement that no fewer than half of all staff members shall be CNA's. Director of Nursing and/or Administrator will review the nursing schedule daily to ensure staffing requirements are met. Director of Nursing will report on adherence to staffing requirements at the quarterly Quality Assurance and	9/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	12006L	A. BUILDING: _____ B. WING _____	C 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 09/22/2023 to 09/28/2023, there were no deficient practices identified for staffing as submitted. 2. For the 2 weeks of staffing prior to survey from 08/04/2024 to 08/17/2024, the facility was deficient in CNAs to total staff on 3 of 14 evening shifts as follows: -08/05/24 had 3 CNAs to 9 total staff on the evening shift, required at least 4 CNAs. -08/06/24 had 5 CNAs to 12 total staff on the evening shift, required at least 6 CNAs. -08/07/24 had 4 CNAs to 10 total staff on the evening shift, required at least 5 CNAs.	S 560	Performance Improvement for the next six months. Completion Date: 9/10/2024	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315146 Y1	A. Building B. Wing Y2	9/13/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	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 F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 09/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
12006L		9/13/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	865 STONE STREET RAHWAY, NJ 07065

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/10/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/23/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING **01** B. WING _____	**08/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	**865 STONE STREET** **RAHWAY, NJ 07065**

(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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/20/2024 and was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. The Building is a four-story building with a basement that was built in the 1950's. Care Connection Rahway (Sub-Acute Care) is located on the fourth floor (4 East). It is composed of Type I protected construction. The facility is divided into two - smoke zones. The facility has two (2) 500 KW and one (1) 350 KW generators and does approximately 100 % of the building as per the Senior Director of Plant Operations. The current occupied beds are 21 of 24.	K 000		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 08/20/2024 in the presence of facility management, it was determined that the facility failed to provide 1 of 4 portable fire extinguishes in a locations identified	K 355	On 8/20/2024, upon observing that a fire extinguisher was missing from the fire hose connection cabinet, the facility's Maintenance Director placed a new fire extinguisher in the cabinet.	9/10/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING **01** B. WING _____	**08/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	**865 STONE STREET** **RAHWAY, NJ 07065**

(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 355	Continued From page 1 in the facility and in emergency evacuation diagrams in accordance with the National Fire Protection Association, NFPA 101: 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10: 2010 Edition. This deficient practice had the potential to affect residents in 14 rooms and was evidenced by the following: A review of the facility provided lay-out at 9:06 AM, revealed the facility is on the fourth floor (4 East) of a four story building with 14 Resident sleeping rooms and common areas on the Unit. Observations starting at approximately 9:40 AM in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), revealed a fire hose connection cabinet with a sign that read, "FIRE EXTINGUISHER" and a wall mounted angled sign "Fire Extinguisher" located across from the conference room. When the Fire Hose Connection cabinet was opened there was no fire extinguisher inside the cabinet. In an interview at the time, the U.S. FOIA (b) confirmed that there should be a fire extinguisher in the cabinet. Along the tour, the surveyor observed two emergency evacuation diagrams. One evacuation diagram map to the left of elevator "E" (#11) and one evacuation diagram across from resident room #431 both identify the two (2) fire hose connection cabinets contain portable fire extinguishers. The U.S. FOIA (b) and U.S. FO confirmed the findings at the	K 355	All residents have the potential to be affected by the missing fire extinguisher. The Administrator will check that all fire extinguishers are in their proper locations once per week for six months. The facility's Maintenance Director will check that all fire extinguishers are in their proper locations once per month. All staff have been in-serviced by the Administrator regarding identifying the location of each fire extinguisher and reporting any missing fire extinguishers immediately to the Administrator. The Administrator will report on audits regarding fire extinguishers being present in their appropriate locations at the facility's quarterly Quality Assurance and Performance Improvement for the next six months. Completion Date: 9/10/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING **01** B. WING _____	**08/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	**865 STONE STREET** **RAHWAY, NJ 07065**

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K 355	Continued From page 2 time of observations. The U.S. FOIA (b) (6) and U.S. FO was informed of the deficient practice during the Life Safety Code survey exit at approximately 1:15 PM. NJAC 8:39 -31.1 (c), 31.2 (e) NFPA 10	K 355		
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 08/20/2024 in the presence of facility management, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection in accordance with NFPA 101: 2012, Section 8.5.4.1. This deficient practice was identified for 2 of 2 sets of corridor double smoke barrier doors tested, had the potential to affect all	K 374	On 8/20/2024, upon observing that two smoke barrier doors in the hallways, adjacent to rooms 432 and 437 were not closing fully, the facility□s Maintenance Director repaired the doors to ensure they close fully. All residents have the potential to be affected by this. All staff have been in-serviced by the Administrator to check that the smoke	9/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING **01** B. WING _____	**08/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	**865 STONE STREET** **RAHWAY, NJ 07065**

(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 374	Continued From page 3 residents on the unit, and was evidenced by the following: A review of the facility provided lay-out at 9:06 AM, revealed the facility is on the fourth floor (4 East) of a four story building with 2 smoke zones, 14 Resident sleeping rooms and common areas on the Unit. Observations starting at approximately 9:40 AM in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), revealed that the 2 sets of smoke barrier doors failed to close into their frames to prevent the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another as follows: 1) At approximately 10:10 AM, the smoke barrier doors next to resident room #432 were released from the magnetic hold-open device and allowed to self-close and one door did not close into the frame. The surveyor observed, measured and recorded a 34-inch opening between the two doors. This test was repeated two additional times with the same results. 2) At approximately 10:18 AM, the smoke barrier doors next to resident room #437 were released from the magnetic hold-open device and allowed to self-close and one door did not close into the frame. The surveyor observed, measured and recorded a 34-inch opening between the two doors. This test was repeated two additional times with the same results. This test was repeated two additional times with the same results. The U.S. FOIA (b) and U.S. FO confirmed the findings at the	K 374	barrier doors close fully when automatically closing during fire drills. The Maintenance Director will manually close the fire barrier doors once per week to ensure they close fully. Any identified issues will be corrected immediately. The Administrator will report on audits regarding proper functioning of smoke barrier doors at the facility□s quarterly Quality Assurance and Performance Improvement for the next six months. Completion Date: 9/10/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315146	A. BUILDING **01** B. WING _____	**08/20/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	**865 STONE STREET** **RAHWAY, NJ 07065**

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K 374	Continued From page 4 time of observations. The U.S. FOIA (b) (6) and U.S. FO was informed of the deficient practice during the Life Safety Code survey exit at approximately 1:15 PM. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315146	A. Building 01 - MAIN BUILDING 01 B. Wing	9/13/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CONNECTION RAHWAY	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 Reg. # NFPA 101 LSC K0355	Correction Completed 09/10/2024	ID Prefix Reg. # NFPA 101 LSC K0374	Correction Completed 09/10/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/20/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO