STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 11, 2022 following New Jersey Department of Health, Health Facility Survey and Field Operations survey on March 22, 2022. At this Comparative Federal Monitoring Survey, Rehab at River's Edge was found not to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness, is NOT MET.	E 000		
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or	E 004		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 004	Continued From page 1 CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to establish and maintain a comprehensive Emergency Preparedness Program, that is updated at least annually and to provide updates to key personnel, including a list of phone numbers for the recall of staff and contacts needed in the event of an emergency. Findings include: Document review and interview on April 11, 2022 at approximately 2:05 PM revealed 'Disaster Manual Plan' did not include an annual update since 2020. Administrator stated 'administrative staff did not review and update the emergency plan in 2021'	E 004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 004	Continued From page 2 The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	E 004		
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment,	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 006	Continued From page 3 including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop and maintain emergency preparedness plan that include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the facility ability to provide care.	E 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 006	Continued From page 4 Findings Include: Document review and interview on April 11, 2022 at approximately 2:10 PM 'Disaster Manual Plan' revealed there was no written documentation related to the management and consequences of power failure and water outage, and fire watch policy did not include for continuing normal operation of the building due to power failure and water outage. The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	E 006		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E 026		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 026	Continued From page 5 (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop, implement and conduct annual updates of emergency preparedness policies and procedures to address the role of the facility under a 1135 Waiver. Findings Include: Document and interview on April 11, 2022 at approximately 2:15 PM revealed facility's 'Disaster Manual Plan' did not include policies and procedures and role of the facility under a 1135 Waiver. The finding was verified by the Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	E 026		
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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	Continued From page 6 Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 11, 2022 following New Jersey Department of Health, Health Facility Survey and Field Operations survey on March 22, 2022. At this Comparative Federal Monitoring Survey, Rehab at River's Edge was found not to be in 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 Occupancies. The facility was originally constructed in 1970s as one-story building Type II (000). The facility is partially sprinklered on domestic water. Emergency backup power to the building was supplied by a gas generator inside the facility. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: quarterly fire drills, fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 138 certified beds. At the time of the survey the census was 126. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 222 SS=E	Egress Doors	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 222	Continued From page 7 CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 222	Continued From page 8 permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide signs at exits with delayed egress locking devices that indicated the procedure for the operation of the delayed release function and exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. The deficient practice could affect 60 of 126 residents at the time of the survey. Findings include: Observation on April 11, 2022 at approximately	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 222	Continued From page 9 10:06 AM Main entrance exit door (interior) revealed delayed egress magnetic lock and a sign 'NOTICE THESE DOORS ARE LOCKED AND ALARMED AT 8:00 PM PLEASE US ROTUNDA DOORS TO EXIT'. There was no signage indicating the procedure to open the door potentially confusing or prohibiting visitors and residents instant use of the facility designated exit in the case of fire or another emergency. Observation on April 11, 2022 at approximately 11:06 AM exit door (wing 4) revealed panic bar, delayed egress magnetic lock and a sign 'PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED AFTER 15 SECONDS'. The releasing of the panic bar device and pushing the door took greater than five pounds of force and timed with a watch at ten seconds to activate the delayed egress mechanism. Surveyor used his full body weight to force open the door because the door was caught against the door frame and plastic draught strip. The releasing of the delayed egress mechanism by pushing the panic bar device and door was not a single action and it took greater than fifteen pounds of force to open the door that could impede or prevent emergency use of such means of egress. Observation on April 11, 2022 at approximately 11:09 AM exit door (wing 3) revealed panic bar, delayed egress magnetic lock and a sign 'PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED AFTER 15 SECONDS'. The releasing of the panic bar device and pushing the door took greater than five pounds of force and timed with a watch at five seconds to activate the delayed egress mechanism. Surveyor used his full body weight to force open the door because the door was caught against the threshold due to	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 222	Continued From page 10 corrosion, door frame and plastic draught strip. The releasing of the delayed egress mechanism by pushing the panic bar device and door was not a single action and it took greater than fifteen pounds of force to open the door that could impede or prevent emergency use of such means of egress. Observation on April 11, 2022 at approximately 11:31 AM exit door (wing 5) revealed delayed egress magnetic lock and a sign 'PLEASE USE MAIN ENTRANCE. There was no signage indicating the procedure to open the door potentially confusing or prohibiting visitors and residents instant use of the facility designated exit in the case of fire or another emergency. Document review and interview on April 11, 2022 at approximately 2:15 PM 'Disaster Manual Plan' revealed there was no documentation and procedure related to locked doors at night and remotely unlocked at an approved, constantly attended location within the locked space. The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 222		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced	K 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 281	Continued From page 11 by: Based on observation and interview, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice could affect approximately 60 of 126 residents. Findings Include: Observation on April 11, 2022 at approximately 10:06 AM Main entrance exit door revealed two switches supplied normal and emergency lighting for the entrance lobby and had no lighting when the switch was in the off position. Observation on April 11, 2022 at approximately 10:21 AM Kitchen revealed two switches supplied normal and emergency lighting for the means of egress and had no lighting when the switch was in the off position. Observation on April 11, 2022 at approximately 10:37 AM Kitchen exit (rear [redacted] revealed two switches supplied normal and emergency lighting for the means of egress and had no lighting when the switch was in the off position. Observation on April 11, 2022 at approximately 10:58 AM White entrance porch revealed two switches supplied normal and emergency lighting for the exterior canopy and had no lighting when the switch was in the off position. Observation on April 11, 2022 at approximately 11:39 AM Lounge corridor ([redacted] revealed all lighting, including the emergency lights could be	K 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 281	Continued From page 12 powered off. The switch in the corridor supplied normal and emergency lighting for the means of egress and had no emergency lighting when the switch was in the off position. The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 281		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly identify doors, with a sign on a door, which is neither an exit nor a way of exit access and is located or arranged so it is likely to be mistaken for an exit shall have a "No Exit" sign and provide directional exit signs in accordance with NFPA 101, 2012 Edition, Section 19.2.10.1 and 7.10. The deficient practice could affect approximately two staff and 30 of 126 residents Findings Include: Observation on April 11, 2022 at approximately 11:22 AM exterior door from corridor into the enclosed courtyard was not an exit, could be	K 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 293	Continued From page 13 confused with an exit and displayed the incorrect sign "NOT AN EXIT". Observation on April 11, 2022 at approximately 11:43 AM Lounge (Wing 5) exterior door into outdoor terrace was not an exit, could be confused with an exit and did not have a "No Exit" sign. The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 293		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 321	Continued From page 14 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide fire barriers with one-hour fire resistance rating and maintain self-closing devices and hardware on doors to hazardous areas in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 8.7.1. The deficient practice could affect approximately 80 of 126 residents. Findings Include: Observation on April 11, 2022 at approximately 10:36 AM Kitchen (rear exit) revealed the door was not self-closing and latching. Observation on April 11, 2022 at approximately 10:40 AM Generator room revealed ceiling penetrations by eight one-inch diameter communication conduit and two data cables sealed with batt insulation and brown foam sealant, Maintenance director was interviewed and stated that sealant was original to the building and it was not known if it was a firestop, Through Penetration System (TPS) installed. Observation on April 11, 2022 at approximately 10:51 AM Mechanical room revealed six two-foot by two-foot section of ceiling tile was not set in	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 321	Continued From page 15 place, ceiling penetrations by twenty communication wiring and twenty five approximately one-inch diameter electrical conduit not fire stopped allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 10:58 AM Beauty Salon revealed it exceeded 50 square feet, contained combustible boxes and linen, there was no self-closing device on the door. Observation on April 11, 2022 at approximately 11:01 AM Laundry revealed there was no self-closing device on the door. Observation and interview on April 11, 2022 at approximately 11:18 AM Oxygen storage room (#504) revealed ceiling penetrations by two approximately one-inch diameter oxygen piping not fire stopped, two four-inch diameter exhaust and supply ducts sealed with brown foam sealant. Maintenance director was interviewed and stated that it was not known if it was a firestop or Through Penetration System (TPS) was not used. Observation on April 11, 2022 at approximately 11:27 AM Rehabilitation storage room revealed it exceeded 50 square feet, contained combustible boxes, equipment and linen. There was no self-closing device on the door. The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 321		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 324	Continued From page 16 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a range hood and maintain grease baffles in accordance with NFPA 101, 2012 Edition, Section 19.3.2.5.1, 9.2.3 and NFPA 96, 2011 Edition. The deficient practice could affect approximately 20 of 126 residents. Findings include:	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 324	Continued From page 17 Observation on April 11, 2022 at approximately 10:24 AM kitchen revealed approximately one two diameter hole in the stove exhaust hood allowing grease-laden vapors enter the exhaust ventilation system. The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	K 324		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to install supervised smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. The deficient practice	K 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 341	Continued From page 18 could affect approximately 40 of 126 residents. Findings include: Observation on April 11, 2022 at approximately 11:24 AM Lounge corridor (Wing 5) revealed skylight located approximately twenty foot above corridor ceiling, there was approximately ten foot by ten foot ceiling not provided with smoke detection. The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	K 341		
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 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)	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 19 This REQUIREMENT is not met as evidenced by: Based on observation and interview, this facility did not properly install sprinklers as required by CMS regulation § 483.90(a) physical environment. Also, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and NFPA 13, 2012 Edition. The deficient practice could affect approximately 60 of 126 residents. Findings Include: Observation on April 11, 2022 at approximately 10:14 AM storage room (adjacent conference room) revealed there was no sprinkler escutcheon fitting to the ceiling allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 10:31 AM kitchen janitor room 2 revealed one sprinkler located in the ceiling tile was corroded. Observation on April 11, 2022 at approximately 11:03 AM storage room ([redacted] Nurse Station) revealed one sprinkler was set level with the ceiling and two-inch gap around sprinkler piping allowing hot gases and smoke pass the sprinkler into the space above. Observation on April 11, 2022 at approximately 11:24 AM Lounge corridor ([redacted]) revealed skylight located approximately twenty foot above corridor ceiling, there was approximately ten foot by ten foot ceiling not provided with sprinkler coverage.	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 20 The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the sprinkler system, ensuring the ceiling level was smoke resisting in accordance with NFPA 101, 2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25, 2011 Edition. The deficient practice could affect approximately 60 of 126 residents.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 353	Continued From page 21 Findings include: Observation on April 11, 2022 at approximately 10:15 AM Administrator Office storage room revealed two-foot by two-foot section of ceiling tile was not set in place, ceiling penetrations by six communication wiring and approximately two-inch diameter data conduit not fire stopped allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 10:16 AM MDS Office storage room revealed ceiling penetrations by five communication wiring and approximately one-inch diameter data conduit not fire stopped allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 10:31 AM Kitchen compressor room revealed three four-foot by two-foot section of ceiling tile not set in place allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 10:47 AM Mens Locker room revealed approximately four-inch diameter ceiling penetration by six communication wiring and approximately one-inch diameter electrical conduit not fire stopped allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 11:10 AM Laundry room revealed two one-foot by four-foot section of ceiling tile was not set in place, ceiling penetrations by four approximately one-inch diameter electrical conduit not fire stopped allowing hot gasses and smoke past the sprinkler into the space above.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 353	Continued From page 22 Observation on April 11, 2022 at approximately 11:15 AM Boiler room ([redacted] revealed ceiling penetrations by four approximately one-inch diameter heating piping not fire stopped allowing hot gasses and smoke past the sprinkler into the space above. Observation on April 11, 2022 at approximately 11:33 AM Sprinkler room [redacted] revealed ceiling penetrations by one-inch diameter heating piping, fifteen communication wiring and approximately two-inch diameter data conduit not fire stopped allowing hot gasses and smoke past the sprinkler into the space above. The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 353		
K 355 SS=E	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 and interview, the facility failed to provide the required instructional placards near the Class K portable fire extinguisher, ensure all portable fire extinguishers were checked monthly and ready for use in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 23 NFPA 10, 2010 Edition. The deficient practice could affect approximately 30 of 126 residents. Findings include: Observation on April 11, 2022 at approximately 10:28 AM in Kitchen revealed K type fire extinguisher did not have the required instructional placard indicating the fire protection system be activated prior to using the fire extinguisher. Observation on April 11, 2022 at approximately 10:29 AM in Kitchen revealed Class ABC extinguisher annual inspection label was March 2022 and inspection tag recorded monthly inspection on 3/14/2022. Observation, document review and interview on April 11, 2022 at approximately 2:30 PM during the exit conference Maintenance Director revealed there was no record of the last twelve monthly inspections for fire extinguishers in the facility. The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 355		
K 362 SS=E	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance	K 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 362	Continued From page 24 rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that corridor walls were constructed to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.6.2 and 19.3.6.2.7. The deficient practice could affect approximately 20 of 126 residents. Findings include: Observation on April 11, 2022 at approximately 10:46 AM Maintenance office revealed approximately two-foot by one-foot transfer grille on the wall discharging air from the room into the corridor. The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	K 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 SS=E	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 observation and interview, the facility failed to provide doors in smoke barrier walls that did not have gaps between the doors to resist fire for a minimum of twenty-minutes in accordance with NFPA 101, 2012 Edition, Section 19.3.7.6, 19.3.7.8 and 19.3.7.9. The deficient practice could affect approximately 40 of 126 residents. Findings Include: Observation on April 11, 2022 at approximately 10:49 AM smoke doors (adjacent break room) when released from magnetic hold-open door device one door did not close, there was a one-half inch opening between doors preventing it from being smoke resistive. The finding was verified by Administrator and	K 374		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 26 Maintenance Director at the time of the observation.	K 374		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to conduct fire drills under varying conditions, locations and simulation of emergency fire conditions in accordance with NFPA 101, 2012 Edition, Section 19.7.1.4 through 19.7.1.7. The deficient practice could affect all residents. Findings Include: Document review and interview on April 11, 2022 at approximately 2:20 PM facility fire drill reports revealed method for the simulation of emergency fire conditions and location were not varied: Date Simulation Location 03.07.22 Trash	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 712	Continued From page 27 Wing 4 02.05.22 Trash Nurses station 01.09.22 Trash Reception 12.30.21 Stove Kitchen 11.11.21 Trash Nurses station 10.09.21 Trash Nurses station 09.22.21 Trash No location identified 08.21.21 Trash Wing 3 07.13.21 Stove Kitchen 06.18.21 Trash Wing 3 05.18.21 No condition identified Wing 2 Report included 'Electrical / Stove / Cigarette / Gas' 04.17.21 No condition identified. Nurses station Report included 'Electrical / Stove / Cigarette / Gas' 03.15.21 Stove Kitchen 02.28.21 Electrical Nurses station 01.21.21 Trash Nurses station The findings were verified by Administrator, Regional Maintenance Director and Maintenance Director at the times of the observation.	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 911	Continued From page 28	K 911		
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility did not demonstrate reliability regarding fuel supply in accordance with NFPA 99, 2012 Edition Chapter 6 and NFPA 110, 2010 Edition, Section 5.1.4. The deficient practice could affect all residents. Findings Include: Document review and interview on April 11, 2022 at approximately 2:25 PM revealed the facility used a natural gas generator, there was no documented reliability letter from the natural gas provider. Reliability letters from natural gas venders regarding fuel supply must contain all of the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement	K 911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 911	Continued From page 29 regarding the low probability of interruption. 5. The signature of technical personnel from the natural gas vendor. The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	K 911		
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not maintain remote annunciator for the emergency generator in accordance with the requirements of NFPA 99, 2012 Edition, Section 6.4.1.1.17, 6.4.1.1.17.5. The deficient practice could affect all residents. Findings include: Observation and interview on April 11, 2022 at approximately 10:18 AM main lobby revealed annunciator for generator 'Lamp Test' was	K 916		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 916	Continued From page 30 activated and 'Low Oil Pressure' light did not illuminate. Administrator stated 'Generator company will be called to fix the fault with the generator' The finding was verified by Administrator and Maintenance Director at the time of the observation.	K 916		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 918	Continued From page 31 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to inspect, test and maintain automatic transfer switch in accordance with the requirements of NFPA 99, 2012 Edition Section 6.4.4, 6.5.4, 6.6.4. NFPA 110, 2010 Edition, NFPA 110, 2010 Edition. NFPA 111, 2011 Edition, Section 700.10. The deficient practice could affect all residents. Findings Include: Document review and interview on April 11, 2022 at approximately 2:35 PM generator records revealed there was no inspection, testing and maintenance records of automatic transfer switch. The finding was verified by Administrator, Regional Maintenance Director and Maintenance Director at the time of the observation.	K 918		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety	K 926		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315140	A. BUILDING **01** B. WING _____	**04/11/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REHAB AT RIVER'S EDGE	**633 ROUTE 28** **RARITAN, NJ 08869**

(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 926	Continued From page 32 guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that personnel responsible for the application, maintenance and handling of medical gases are trained on the risks, safety and usage requirements including location of medical gas shut off valve in the event of an emergency in accordance with the requirements of NFPA 99, 012 Edition, Section 11.5.2.1. The deficient practice could affect approximately 20 of 126 residents. Findings include: Observation and interview on April 11, 2022 at approximately 11:40 AM room 504 revealed sign on the door "OXYGEN IS USE', in the room Staff A was attending to a resident on oxygen and did not know the location of the medical gas shut off valve. Observation and interview on April 11, 2022 at approximately 11:40 AM nurse station [redacted]) Staff B did not know the location of the medical gas shut off valve. The findings were verified by Regional Maintenance Director and Maintenance Director at the times of the observation.	K 926		