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	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Care Connection Rahway	865 Stone Street Rahway, NJ 07065

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility provided documents, it was determined that the facility failed to 1). label food packages when opened and 2). protect food by covering or closing opened packages to minimize the risk for contamination or the development or growth of pathogens that could result in food-borne illness.This deficient practice was evidenced by the following: On 12/16/25 at 8:32 AM, the surveyor toured the kitchen with the Director of Food Service (DFS) and observed:1. Two (2) opened containers of spices (pickling spice and black pepper) on a top shelf in the dry storage area. The DFS was not able to identify the date either container was opened and acknowledged that the containers should have been dated when opened. The DFS removed both containers from the dry storage area. 2. One (1) opened, approximately half full, ten-pound bag of uncooked pasta with the top of the bag tied in a knot. The DFS acknowledged there was no date marked on the package to identify when the bag was opened, and there should have been. She removed the bag from the dry storage area. 3. An unlabeled, undated bulk item with the top of the bag tied closed, on a shelf in the produce refrigerator. The DFS identified the item as chopped onions and acknowledged the bag should have been dated when opened, but was not. She removed the bag from the refrigerator shelf.4. An opened container labeled as hummus on a shelf in the produce refrigerator. The lid had 11/14 hand-written in black ink. When asked by the surveyor what the shelf life of this opened product was, the DFS stated that's expired and removed the container from the refrigerator shelf. She did not provide any additional information about the item at that time. On 12/16/25 at 8:51 AM, in the presence of the DFS and surveyor, the Regional Food Service Director (RFSD) joined the kitchen tour. The surveyor observed the following:5. There was an opened (product exposed to the air), undated box of sausage links on a shelf in the stand up refrigerator. The RFSD stated the sausage was probably used for breakfast and acknowledged the box should not have been left opened to the air. The DFS acknowledged the product should have been dated when opened, and the package should have been closed. 6. There was an unlabeled, undated plastic bag with the top twisted closed on a shelf in the stand up refrigerator. The bag contained 6 whole white oval items in a liquid. The DFS stated this product was precooked hard boiled eggs, and they come that way from the distributor. The DFS acknowledged that the bag should have been dated when opened. The DFS removed the bag from the refrigerator. At that time, the DFS stated, I don't know why we don't have open dates. The DFS stated their process was to write the date on any package of food when it was opened. She acknowledged that the kitchen staff would refer to the opened date to determine whether an item could be used or needed to be discarded. The surveyor reviewed the following facility provided documents.A policy and procedure titled Role of Food Service Director dated 11/02 revealed the food service director responsibilities included directing and coordinating the daily activities of the department. in carrying out the department's established policies.An undated policy and procedure titled Kitchen Food dating/Expiration policy reflected that dry products that have been opened and wrapped to save the rest of the container will have an opened date, and will have 30 days from the date opened. This did not pertain to condiments, dry spices, dry herbs, or dry pasta. which would go to the product recommended expiration date as first priority. If no expiration date could be read, then (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6 months would be the secondary date.On 12/18/25 at 11:51 AM and on 12/19/25 at 9:44 AM the surveyor requested additional information specifically with regard to safe food storage, policy and procedure for opened temperature sensitive/refrigerated food, and food hygiene standards used to identify and control potential hazards during food production that could result in food contamination or food borne illness. The DFS, RFSD, and administrator were aware of this request. No additional information was provided that was pertinent to food safety and food hygiene standards. According to the Food and Drug Administration 2022 Food Code, Adoption of the Food Code represents a successful federal/state/local/tribal partnership in improving food safety. However, adoption without instituting meaningful foodborne illness interventions and a strong regulatory program infrastructure is not effective. With the current initiative to reduce the occurrence of risk factors known to cause foodborne illness, the primary focus is appropriately shifting to measures of success beyond Food Code adoption. These include tracking risk factor occurrences over time by comparing baseline improvements in inspection data and follow-up inspection findings; use of risk- based inspections; applying HACCP principles; and uniformly implementing Food Code provisions. NJAC 8:39-17.2 (g)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interviews, record review and review of pertinent facility documents, it was determined that the facility failed to obtain a physician's order for oxygen therapy provided to one of one resident (Resident #1) reviewed for oxygen therapy. This deficient practice was evidenced by the following: On 12/16/25 at 9:03 AM, during the initial tour of the unit, the surveyor observed Resident #1 seated in a wheelchair in their room, receiving oxygen (O2) via nasal cannula at 5 liters per minute (lpm). On 12/17/25 at 10:47 AM, the surveyor observed Resident #1 lying in bed receiving O2 at 5 lpm. There was a sign on the door to the room which read No smoking/no open flames for oxidizing gases.The surveyor reviewed the electronic medical record (EMR) and the hybrid chart (printed and handwritten medical records) for Resident #1.A review of the admission record revealed diagnoses which included but were not limited to; pneumonia (an infection that inflames the air sacs in one or both lungs), acute respiratory failure with hypoxia (a condition in which the body's tissues do not get enough oxygen), and pleural effusion (buildup of excess fluid between lungs and chest wall). A review of the comprehensive Minimum Data Set (a resident assessment and care screening tool) dated 12/3/25, revealed the resident had a Brief Interview for Mental Status of 10 out of 15, indicating the resident was moderately cognitively impaired. Further review reflected the resident received a respiratory treatment of continuous oxygen therapy on admission and while a resident. A review of the individual comprehensive care plan (ICCP) revealed a focus of oxygen therapy r/t (related to) ineffective gas exchange, date initiated 11/3/25, with an intervention of give medications as ordered by physician. A review of the Medication Review Report [an electronic summary of all active and discontinued physician orders] did not reflect a physician's order for oxygen. A review of the November 2025 and December 2025 electronic medication administration record (EMAR) and electronic treatment administration record did not reflect an order for oxygen. A review of the Physician's Orders forms from 11/28/25 at 12:00 AM until 12/17/25, did not reflect an order for oxygen. On 12/17/25 at 11:36 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated Resident #1 was on her assignment today. LPN #1 stated Resident #1 was on O2 at 5 lpm continuously via nasal cannula since they were readmitted from the hospital. On 12/17/25 at 11:45 AM, the surveyor interviewed the Director of Nursing (DON), who stated if a resident was receiving oxygen, they would have an order from the physician in the EMR. In the presence of the surveyor, the DON reviewed the EMR for Resident #1 and acknowledged the EMR did not contain a physician's order for oxygen. On 12/17/25 at 11:50 AM, the surveyor re-interviewed LPN #1, who stated there should be a physician's order for oxygen in the EMR for Resident #1. At this time LPN #1, in the presence of the surveyor, reviewed the EMR. LPN #1 acknowledged there was not an order for oxygen for the resident. She stated their (the facility) process was to add all physician orders to the EMR when the resident arrived on the unit from the hospital. LPN #1 stated she would call the physician now to obtain an oxygen order for Resident #1.On 12/18/25 at 9:38 AM, the surveyor re-interviewed the DON, who stated that each nurse, during their shift, should have compared the resident's oxygen flow meter to the physician orders and if there was a discrepancy, they (the nurse) should have called the doctor to clarify the order. On 12/18/25 at 11:51 AM, during a meeting with the survey team, the DON acknowledged Resident #1 was on oxygen since they were admitted from the hospital, and there should have been a physician's order. The DON stated there was a transcription error by the nurse, that the order was not put in. A review of the policy and procedure for Admission with last reviewed date of 9/2025, revealed it was the policy of the facility that a resident is received, made comfortable, assessment completed, and orders written upon admission. The purpose was to ensure that all needs were identified, and medications/treatments were ordered based on the assessment and transfer documentation. A review of the policy and procedure for Oxygen Administration, with a last reviewed date of 9/2025, revealed the purpose of this procedure was to provide guidelines for safe oxygen administration. Preparation:1.Verify there was a physician's order for the procedure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review the physician's orders or facility protocol for oxygen administration, (for new admission check hospital discharge summary for oxygen orders and verify with admitting MD).Documentation: 1. After completing the oxygen setup or adjustment, the nurse should sign the resident's record/EMAR. N.J.A.C. 8:39-11.2 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure communication forms between the facility and a contracted dialysis facility were consistently completed according to facility policy and procedure. This deficient practice was identified for 1 of 1 resident reviewed for dialysis (Resident #6). The deficient practice was evidenced by the following: On 12/16/25 at 9:07 AM, during initial tour of the facility, the surveyor observed Resident #6 being transported out of the facility by a transport company to a dialysis center. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; end stage renal disease (kidneys have permanently lost their ability to function) and type two diabetes mellitus (body does not use insulin properly). A review of the comprehensive Minimum Data Set, an assessment tool dated 11/17/25, revealed a Brief Interview for Mental Status score of 4 out of 15, which indicated the resident had severely impaired cognition. Further review of Section I revealed diagnoses of renal insufficiency, renal failure, and end stage renal disease and Section O, Resident #6 received dialysis while residing at the facility. A review of the Order Summary Report included a physician's order (PO) dated 11/11/25, for dialysis at [dialysis center name redacted] on Tuesday, Thursday, and Saturday at 9:30 AM. A review of the individualized comprehensive care plan (ICCP) included a focus area dated 10/5/25, that the resident needed hemodialysis related to renal failure. Interventions included but were not limited to; change dialysis site dressing as needed and do not draw blood or take blood pressure in the arm with the graft. The ICCP also included a focus area dated 10/5/25, that the resident had renal failure related to end stage disease. Interventions included: assess for presence of bruit and thrill every shift and notify the physician if absent and assist the resident with activities of daily living (ADL's) and ambulation as needed On 12/17/25 at 12:40 PM, the surveyor reviewed Resident #6's dialysis communication book that was to be sent with the resident on dialysis treatment days. The communication forms were reviewed from November 2025 to December 2025. On the following dates the dialysis communication forms were not completed by the facility nurse upon the resident's return from dialysis: 11/6/25, 11/13/25, 11/15/25, 11/17/25, 11/20/25, 11/22/25, 11/24/25, 11/29/25, 12/4/25, 12/9/25, 12/11/25, and 12/13/25. The dialysis communication forms were not completed by the dialysis center on 11/20/25, 11/29/25, and 12/13/25. A review of the skilled need noted in the eMAR (electronic medical record) did not reveal a full set of vital signs or assessment of bruit or thrill upon return from dialysis for the following dates: 11/6/25, 11/13/25, 11/15/25, 11/17/25, 11/20/25, 11/22/25, 11/24/25, 11/29/25, 12/4/25, 12/9/25, 12/11/25, and 12/13/25. On 12/17/25 at 1:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN), who stated Resident #6 went out for dialysis on Tuesday, Thursday, and Saturday. The LPN further stated that prior to Resident #6's departure the nurse would give the resident their medications, obtain vital signs, monitor the access site, and document it on the dialysis communication form that was to be sent to the dialysis visit with the resident. The LPN also stated that when the resident returned from dialysis, the nurse would obtain vital signs, monitor the access site for drainage, bruit and thrill and document it in section three of the communication form. The LPN stated that if the dialysis center does not fill out their section, the facility would call the center to see what they did at the dialysis center and if there were any new orders or changes to care. She also stated that upon return from dialysis, the nurse would obtain vital signs and review the dialysis communication form. She stated the importance of the communication form was for communication and to know how the resident had tolerated the dialysis treatment. On 12/18/25 at 10:26 AM, the surveyor interviewed the Director of Nursing (DON), who stated that prior to a resident going out to dialysis, the nurse would monitor and assess the dialysis site, obtain vital signs and fill out the dialysis communication form. She stated the dialysis center would review and complete their section of the dialysis form with vital signs and pre and post weights. She also stated that the nurse was responsible to complete and (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review the dialysis communication form upon return from dialysis. She further stated that the purpose of the dialysis communication form was to ensure communication between the facility and dialysis center and for continuity of care. The surveyor asked the DON if the dialysis center were to leave section two blank, what should the nurse do. The DON replied that the nurse should call the dialysis center to find out if there were any new orders, medications that were given, or any concerns. The DON acknowledged that the dialysis communication forms were not filled out completely on the following dates: 11/6/25, 11/13/25, 11/15/25, 11/17/25, 11/20/25, 11/22/25, 11/24/25, 11/29/25, 12/4/25, 12/9/25, 12/11/25, and 12/13/25. On 12/18/25 at 11:00 AM, the DON, in the presence of the Licensed Nursing Home Administer (LNHA), Assistant Director of Nursing (ADON), and the survey team, stated the importance of the dialysis communication forms was to ensure communication between the facility and the dialysis center. The DON also stated that the dialysis communication form should be completed in its entirety and should have no blank areas. A review of the facility's Dialysis policy reviewed, 1/2025, included orders for checking of the dialysis access site, presence of bruits and thrills, checking site/area for bleeding, redness, etc will also be included.a dialysis progress notebook will be sent with the resident during dialysis day to be completed by the center and may be returned to the facility with the latest lab result and any other recommendation from the center/clinic. receiving nurse will review communication form and update MD and update residents care if necessary. A review of the facility's Documentation policy, reviewed on 1/2025, included.to ensure accurate, timely, and complete documentation of each resident's care in the medical record.documentation must be completed as soon as possible. Documentation must include, date and time of entry, description of the resident's condition or care provided, resident response, when applicable, signature, initials, and title of the staff member. Documentation must follow facility guidelines for either electronic or paper medical records. N.J.A.C. 8:39-27.1 (a)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and review of facility documents, it was determined that the facility failed to ensure that the centrally located call bell device used to identify call bell notifications at the nurse's station was functioning properly.This deficient practice was evidenced by the following:On 12/17/2025 at 12:41 PM, the surveyor observed a white call bell light illuminate over the door for room [ROOM NUMBER], while standing at the nurse's station. The surveyor observed a call bell device system at the nurse's station. The system's screen was blank and there was no alarm indicating a call bell was on.On 12/17/2025 at 12:49 PM, while the surveyor was standing behind the nurse's station, she heard a call bell alarm. The centrally located call bell system at the nurse's station screen was blank and there was no alarm indicating a call bell was on. The surveyor walked around the unit and observed the white call bell for room [ROOM NUMBER] was illuminated.On 12/17/2025 at 1:06 PM, the surveyor interviewed Certified Nursing Aide (CNA) #1, who stated when a resident used their call bell, she would hear the alarm and then she would have to walk around the unit to find out what room had the call bell on. On 12/17/2025 at 1:08 PM, the surveyor interviewed CNA#2, who stated if a resident needed assistance they sometime would yell for help or use their call bell. He stated he would hear the call bell alarm and look for the light. He added he could also look at the call bell system at the nurse's station to determine what room needed assistance.On 12/17/2025 at 1:15 PM, the surveyor interviewed the Licensed Practical Nurse, who stated if she heard a call bell alarm she would look for the light but if she was sitting at the nurse's station she would look at the call bell device to see what room needed assistance, she added, if it was working, they may be in the process of fixing it. She was unable to tell the surveyor if the call bell device at the nurse's station was currently working. On 12/17/2025 at 1:23 PM, while at the nurse's station, the surveyor heard another type of an alarm. The centrally located call bell system at the nurse's station screen was blank and there was no alarm indicating a call bell was on. The surveyor walked around the unit and observed a flashing red light call bell for room [ROOM NUMBER] was illuminated. On 12/17/2025 at 1:30 PM, the surveyor interviewed the Director of Nursing (DON), who stated if a call bell was activated, staff would hear an alarm and walk around to look for the alarm. She added, there would be a beep at the call bell system at the nurse's desk to see where the call bell was. She stated the call bell device system would light up. On 12/17/2025 at 1:33 PM, the Licensed Nursing Home Administrator (LNHA) pressed the call bell for room [ROOM NUMBER]. The white call bell illuminated above the door. The DON showed the surveyor the call bell system at the nurse's station. The LNHA and the DON both acknowledged the call bell device at the nurse's station was not working. The LNHA checked to make sure the system was plugged in, in which it was. The DON stated it should illuminate with the room number and alarm.On12/17/2025 at 1:40 PM, while the surveyor was standing behind the nurse's station, she heard a call bell alarm. The centrally located call bell system at the nurse's station screen was blank and there was no alarm indicating a call bell was on. The surveyor walked the unit and observed the white call bell illuminated for room [ROOM NUMBER]. The call bell light was unable to be visualized from the nurse's station because the room was located on the other side of the double doors.On 12/17/2025 at 1:44 PM, the surveyor observed CNA #2 standing in the hallway between the nurse's station and the Men's bathroom. CNA#2 looked down the hallway towards room [ROOM NUMBER] but turned around and walked the opposite way. At 1:49 PM, CNA #2 answered the call bell for room [ROOM NUMBER]. On 12/18/2025 at 10:20 AM, the surveyor interviewed the DON, in the presence of the LNHA. The DON stated we called maintenance. The LNHA stated the system was not functioning. He stated they called the hospital maintenance, who came and checked it but could not get it (the call bell device) working. On 12/18/2025 at 11:51 AM, in the presence of the survey team, the surveyor made the LNHA, the DON and the Regional Nurse (RN) aware of the above concerns.On 12/18/2025 at 12:06 PM, in the presence of the RN and the survey team, the staff (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member responsible for overseeing the system, stated We (the facility) have no control over the call bell system. It is an old phone system phone on the nurses' desk, but we found a replacement part and were able to fix it. A review of the facility's policy Call Bell Response Policy reviewed 1/2025 revealed Policy: It is the policy of Alaris Health at Care Connections to ensure that all residents have timely access to staff assistance through a functioning call bell system in order to promote resident safety, dignity, comfort, and quality of care.N.J.A.C 8:30-31.2 (e)