STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	**100 PLAINSBORO ROAD PLAINSBORO, NJ 08536**

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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 Complaint #: NJ 153361, NJ 154800, NJ 154946, NJ 155276, NJ 155975, NJ 156125, NJ 157434, NJ 158378, NJ 159556, NJ 159803 Survey Date: 11/22/23 Census: 144 Sample Size: 35+17 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 609		12/15/23

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

Electronically Signed | 12/10/2023

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.

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F 609	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ00156125 Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to report an allegation of abuse to the New Jersey Department of Health (NJDOH) for 1 of 5 residents reviewed for investigations and was evidence by the following: A review of Resident #296's Admission Record Face Sheet (an Admission summary) reflected that the resident was admitted to the facility with diagnosis which Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] A review of Resident #296's Admission Minimum Data Set (MDS), an assessment tool, dated Exec Order 26, 4b [redacted], revealed the resident had a Brief	F 609	I. - The Resident #296 was discharged from the facility on Exec Order 26, 4b1 NJAC [redacted] and was no longer an active resident during the time of the Department of Health (DOH) Annual Survey visit on 11/13/2023. - Current Administrator and DON were not Administrator and DON of record during the time this deficient practice took place. II. - All facility residents have the potential to be affected by the same deficient practice. III. - For the current residents facility will report alleged violations, if any, to the State Agency, adult protective services and to all other required agencies with specified timeframes: a) immediately, but not later than 2 hours after the allegation	

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F 609	Continued From page 2 Interview for Mental Status (BIMS) score of [redacted] On 11/20/23 at 1:15 PM, the surveyor reviewed a facility document dated [redacted] titled "Resolution to Resident Grievance/Complaint Form" for Resident #296. The grievance form revealed that on [redacted] that the resident [redacted] Attached to the grievance form was an investigation dated [redacted] which revealed the facility concluded that there was no indication of [redacted] of Resident # 296. A review of the police incident report provided by the facility, dated [redacted], revealed Resident #296 had called the police on [redacted] and explained to the police that they [redacted] by the nursing supervisor and was not receiving the correct care. On 11/20/23 at 2:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding Resident #296's grievance and investigation. The LNHA stated when conducting that type of investigation, she would have reported an allegation of abuse to the NJDOH. The LNHA stated that she could not find documentation to confirm that the investigation was reported to the NJDOH. A review of the facility's policy reviewed a Policy labeled "Abuse, Neglect and Exploitation which the most recent date of 9/2023, which included but was not limited to; section VII reporting/response:	F 609	is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b) not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury. - Regional Clinical Director will proactively re-train Administrator/DON on facility Reportable Events/Abuse Neglect and Exploitation Prevention policy and procedures. - Administrator/Designee will re-train all facility staff on Reportable Events/Abuse Neglect and Exploitation Prevention policy and procedures to ensure that facility notifies the Department's Assessment and Survey Unit of reportable events in accordance with all applicable State and Federal regulations. - Administrator/Designee will educated all newly hired employees on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. - When an incident or suspected case of resident abuse, neglect, misappropriation of resident property, or injury of unknown source is reported , the Administrator/DON/Designee will investigate/report the incident in accordance with the facility Abuse, Neglect and Exploitation policy and procedures. - All facility employees will continue to follow facility policies and procedures on preventing and prohibiting all types of abuse, neglect, misappropriation of resident property, and exploitation. IV.	

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F 609	Continued From page 3 1. reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies with specified timeframe's; a. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. NJAC 8:39-4.1(a)(5)	F 609	- Administrator/DON/Designee will conduct random audits of all facility incidents/accidents to determine any risk factors such as history of aggressive behavior, environmental factors, etc. that could contribute to abuse, and whether there is further need for systematic actions such as increased training on specific components of identifying and reporting that staff may not be aware of or are confused about; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Administrator/DON/Designee will conduct random audits on all incidents/accidents to ensure timely identification, assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meetings for six (6) months for review and revision as deemed appropriate.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		12/31/23

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F 656	Continued From page 4 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 5 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan. This deficient practice was identified for 1 of 30 residents (Resident #124) reviewed for care plans and evidenced by the following: On 11/13/2023 at 12:47 PM, the surveyor observed Resident #124 with an Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] The surveyor reviewed the medical record for Resident #124: A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ Exec. Order 26:4.b.1 [redacted], reflected a brief interview for mental status (BIMS) score of Exec Order [redacted] A review of the individualized comprehensive care plan (ICCP) failed to include a focus area and interventions that identified Resident #124's NJ Exec. Order 26:4.b.1 [redacted]. A review of Resident #124's electronic medical record Physician Progress Note entered on	F 656	I. -For the Resident #124 individualized comprehensive care plan (ICCP) was updated to include a focus area and interventions regarding resident's NJ Exec. Order 26:4.b.1 [redacted] immediately. - DON/Designee re-trained all nursing staff on facility policy and procedures on completion of ICCP immediately. II. - All facility residents have the potential to be affected by the same deficient practice. III. - All newly admitted and current facility residents will have individualized comprehensive care plans that meet their needs, set goals and interventions and make nursing staff aware of how to care for the residents. - All care plans will be updated as new needs/problems/concerns arise, and formally reviewed by the Interdisciplinary Team at least quarterly. - DON/Designee will continue in-service all nursing staff, including newly hired nursing staff, on facility policies and procedures on completing individualized comprehensive care plans for newly admitted/current residents as per State and Federal Regulations; the care plans must meet all residents' needs, set goals for them and make nursing staff aware of how to care for residents.	

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F 656	Continued From page 6 Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] A subsequent Nursing Skin Evaluation entered on Exec Order 26, 4b1 NJAC, noted that the resident Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] On 11/17/23 at 10:55 AM, the surveyor interviewed Licensed Nurse Practitioner (LPN #2), who acknowledged that care plans are utilized to render care to residents based on their behaviors, personal preferences, and independence. LPN #2 confirmed that the resident's care plan should identify their NJ Exec. Order 26:4.b.1 [redacted]. On 11/20/2023 at 11:08 AM, the surveyor interviewed Registered Nurse Unit Manager (RN/UM#2), who acknowledged that a care plan is a tool used to communicate the status and preferences of the resident needs to everyone involved in their care. RN/UM #2 stated that Resident #124's Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] and refusal of evaluation should have been identified on the care plan. On 11/20/2023 at 11:08 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of Clinical Regional Nurse (CRN), who stated that a care plan was used to identify areas for patient review and improvement. The DON and CRN stated that Resident #124's Exec Order 26, 4b1 [redacted] should be careplanned. A review the facility's "Comprehensive Care Plan" documentation, included [...] 3. The comprehensive care plan will describe, at a minimum, the following ...a- the services that are	F 656	IV. - Unit Managers/Designee will conduct audits for the unit residents to ensure that all newly admitted and all current residents have comprehensive care plans that meet residents' needs, set goals and interventions and make nursing staff aware of how to care for the residents; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - DON/Designee will conduct random audits for all current residents to ensure that all newly admitted and all current residents have comprehensive care plans that meet residents' needs, set goals and interventions and make nursing staff aware of how to care for the residents; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - DON/Designee will conduct spot audits on comprehensive care plan completion; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) meetings for six (6) months for review and revision as deemed appropriate.	

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F 656	Continued From page 7 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b-Any services that would otherwise be furnished ,but are not provided due to the resident's exercise of his or right to refuse treatment. A review the facility's "Position Title: Licensed Practical Nurse responsibilities/Accountabilities:" documentation, included: Under supervision of the Director of Nursing, the incumbent utilizes a general understanding of the principles of nursing and basic physical assessment skills in the development of and implementation of individualized nursing care plans to ensure that the needs of the resident are met [...] formulates individualized nursing care plans utilizing the nursing progress. NJAC8:39-11.2(e) thru (i); 27.1(a), (d)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # NJ00158378 Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) follow a physician's order to obtain weekly weights for 1 of 5 residents (Resident #251) investigated for [redacted] b.) notify a physician of a resident's	F 658	I. - Resident #251 was [redacted] as per physician order for the rest of her subacute stay; on [redacted] The resident was discharged from the facility on [redacted] - Resident #254: on 11/17/23, resident was interviewed and offered a [redacted]	12/31/23

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F 658	Continued From page 8 medication refusal for 1 of 4 residents (Resident #254) investigated [redacted] c.) follow a physician's order (PO) to notify if a resident's [redacted] for 1 of 30 residents (Resident #58) reviewed for medications d.) enter a progress note related to an unwitnessed [redacted] for 1 of 4 residents (Resident #58), investigated for accidents and incidents and e.) document the administration of medication on the resident's electronic medication administration record (eMAR) for 1 of 30 residents (Resident #292) reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and	F 658	[redacted] as intervention for [redacted] history of [redacted] Resident denied any urge for smoking and refused nicotine patch; individualized comprehensive care plan reflects resident's wish. The caring nurse received verbal one-on-one education on facility Refusal of Treatment policy and procedures. -The Resident #292 was discharged from the facility on [redacted] and was no longer an active resident during the time of the Department of Health (DOH) Annual Survey visit on 11/13/2023. - Resident #58; [redacted] was recorded/documented into the Risk Management tool, initial nursing note was recorded in PCC to reflect a [redacted] event immediately; investigation was completed as per facility Incident/accident policy and procedures. II. -All residents have the potential to be affected by the same deficient practice. III. - DON/Designee will re-educate all nursing staff on facility Weight Monitoring policy and procedures to maintain acceptable parameters of nutritional status as well as body weight and protein level of the facility residents; unless the resident's clinical condition demonstrates that it is not possible. - All nursing staff will follow facility Weight Monitoring policy and procedures to ensure that all weights are completed and recorded as ordered. - DON/Designee will re-educated all	

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F 658	Continued From page 9 restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 11/15/23 at 1:03 PM, the surveyor observed Resident # 251 seated in a wheelchair in their room. The resident stated they were [NJ Exec. Order] [redacted] The resident further stated they were on a [NJ Exec. Order 26:4.b.1] [redacted] and had spoken to both the kitchen and the dietician regarding their food preferences. The surveyor reviewed the medical record for Resident #251. A review of the resident's Admission Record indicated the resident was admitted to the facility in [Exec Order 26, 4b1 NJAC 8:43E-2.1] with diagnoses which included a [Exec Order 26, 4b1 NJAC 8:43E-2.1] [redacted] A review of the resident's October 2023 Order Summary Report revealed a PO dated [Exec Order 26, 4b1] that read "for [NJ Exec. Order 26] each Tuesday 10/24, 10/31, 11/7, 11/14 one time a day every 4 weeks on Tue." A review of the resident's October [Exec Order] eMAR did not reveal a PO dated [NJ Exec. Order 26:4.b] that read "for [NJ Exec. Order 2] each Tuesday 10/24, 10/31, 11/7, 11/14 one time a day every 4 weeks on Tue". A review of the order details revealed when the PO was entered into the electronic medical record (eMAR) the nurse failed to indicate that documentation on the eMAR was required.	F 658	nursing staff on the facility Medication Administration policy and procedures to ensure safe, accurate and timely administration of medications, including that all physician orders are followed and if a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time the licensed nurse enters it under the appropriate code in the electronic MAR and documents the reason in the electronic clinical record. - All nursing staff will follow the facility Medication Administration policy and procedures to ensure the safe, accurate and timely administration of medications, including that all physician orders are followed and if a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time the licensed nurse enters it under the appropriate code in the electronic MAR and documents the reason in the electronic clinical record. - DON/Designee will re-educated all nursing staff on proper electronic MAR documentation of medication administration, including taking vital signs where appropriate, electronically initialing MAR by the person administering medication, immediately after administration of the medication. - All nursing staff will follow facility policy and procedures on completing electronic MAR documentation of medication administrations, including taking vital signs where appropriate, electronically initialing MAR by the person administering medication, immediately after	

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F 658	Continued From page 10 On 11/17/23 at 12:39 PM, the surveyor interviewed the resident's Licensed Practical Nurse #3 (LPN #3) who stated residents on the subacute wing were weighed every Tuesday by the Certified Nurse Aides (CNAs). The CNAs would relay the weights to the nurses who would then enter the weights into the eMAR for each resident. The weights could be viewed on the "dashboard" section of the eMAR. On 11/17/23 at 12:47 PM, together with LPN #3 the surveyor reviewed the eMAR which revealed the resident's [NJ Exec. Order 26] had been documented on two dates only [NJ Exec. Order 26:4.b] and [NJ Exec. Order 26]. The LPN acknowledged there should have been [NJ Exec. Order 26:4] documented on NJ Exec. Order 26:4.b.1 and [NJ Exec. Order 26:4.b]. LPN #3 then reviewed the order details for the PO dated [Exec Order 26, 4b1] regarding acquiring weekly [NJ Exec. Order 26:4.] and acknowledged the order had been entered incorrectly and the required [NJ Exec. Order 2] did not carry over to the eMAR for scheduling. On 11/17/23 at 12:55 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM1) who stated residents were weighed on admission and every week on Tuesday. The RN/UM1 stated the CNAs used the daily census sheet as a guide to make sure no resident was missed. The weights are reviewed by nursing and the dietician for weight loss, gain, or any discrepancy usually on Wednesdays. The surveyor and the RN/UM1 then reviewed the resident's eMAR and she acknowledged the [NJ Exec. Order 26] had not been recorded according to the PO. On 11/21/23 at 2:00 PM, the surveyor interviewed the Director of Nursing (DON) who stated the	F 658	administration of the medication. - DON/Designee will re-educate all nursing staff on facility policy and procedures on medical documentation to ensure that all significant events relative to falls, resident's condition, behavior or response to treatment(s) be documented in the electronic clinical record. - All nursing staff will follow facility policy and procedures on medical documentation to ensure that all significant events relative to falls, resident's condition, behavior or response to treatment(s) be documented in the electronic clinical record. IV. - Registered Dietician/Designee will conduct random audits on all weights that are completed and recorded as ordered; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - DON/Designee will conduct random audits on completing of the electronic MARs to ensure the safe, accurate and timely administration of medications, including that if a dose of regularly scheduled medication is withheld, refused or given at other than the scheduled time the licensed nurse enters it under the appropriate code in the electronic MAR and documents the reason in the electronic clinical record; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed.	

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F 658	Continued From page 11 nurses should have followed the physician's orders for [NJ Exec. Order 26:4.b.1]. The DON further stated she had checked the nursing unit to ensure the resident's [NJ Exec. Order 26:] had not been recorded elsewhere and was unable locate any documentation the [NJ Exec. Order 26:] had been recorded according to the physician's order. A review of the facility's undated "Weight Monitoring" policy included... Weight can be a useful indicator of nutritional status... weights should be recorded at the time obtained. Suggested weight schedule... Newly admitted residents- weekly for four weeks... 2. On 11/15/23 at 12:22 PM, the surveyor observed Resident #254 in their room who stated [Exec Order 26, 4b1 NJAC 8:43E-2.1] When asked the resident stated they would not [Exec Order 26] on campus but would occasionally when out of the facility with family. The surveyor reviewed the medical record for Resident #254. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in [Exec Order 26, 4b1 NJAC 8:] with diagnoses which included [Exec Order 26, 4b1 NJAC 8:43E-2.1] A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [Exec Order 26, 4b1] reflected a brief interview for mental	F 658	- DON/Designee will conduct random audits on completing electronic MAR documentation of medication administrations, including taking vital signs where appropriate, electronically initialing MAR by the person administering medication, immediately after administration of the medication; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - DON/Designee will conduct random audits on medical documentation to ensure that all significant events relative to fall, resident's condition, behavior or response to treatment(s) be documented in the electronic clinical record; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly Quality Assurance Performance Insurance (QAPI) meeting for six (6) months for review and revision as deemed appropriate.	

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status (BIMS) score of [redacted] which indicated Exec Order 26, 4b1 NJAC 8:43E-2.1

A review of the individualized comprehensive care plan reflected a focus area initiated [redacted] indicating the resident was [redacted] Interventions included a [redacted] had been ordered.

A review of the Order Summary Report included a PO dated [redacted] for Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]

A further review revealed a second PO dated [redacted] for Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]

A review of the October 2023 MAR reflected the following:

The medication order for [redacted] was scheduled daily at 9:00 AM, from 10/1/23 until 10/4/23. On 10/1/23, 10/2/23 and 10/3/23 the nurse entered the code "5". According to the chart codes "5" indicated "hold /see nurse notes."

A review of the corresponding progress notes revealed the resident had refused the medication.

The medication order for Exec Order 26, 4b1 NJAC 8:43E-2.1 was scheduled daily at 9:00 AM, from 10/5/23 until 10/18/23. On 10/7/23, 10/8/23 and 10/12/23 the nurse entered the code "5."

A review of the corresponding progress notes

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revealed the resident had refused the medication.

A further review of the medication order for [redacted] revealed on 10/5/23, 10/9/23, 10/10/23, 10/11/23 and 10/13/23 the nurse entered the code "2". According to the chart code "2" indicated drug refused.

A review of the progress notes for October 2023 did not reveal documentation that the resident's physician had been made aware the resident had been refusing their [redacted] administration.

On 11/17/23 at 1:20 PM, the surveyor interviewed LPN #3 who stated that if a resident refused a medication, she would be prompted by the system to document in the progress notes the resident's refusal. She also stated if the resident refused a medication on multiple occasions, she would contact the physician for guidance.

On 11/17/23 at 1:29 PM, the surveyor interviewed RN/UM #1 who stated the resident had the right to refuse a medication, but the nurse was responsible to document the refusal in the eMAR. If the medication was critical then the physician must be notified immediately.

On 11/21/23 at 2:00 PM, the surveyor interviewed the DON who stated the nurses should reach out to the physician if a resident refused a medication. The DON acknowledged the nurses should have made the physician aware of the [redacted] refusal.

A review of the facility's "Refusal of Treatment" policy dated 2/2023 included... Documentation pertaining to a resident's refusal of treatment shall include at least the following...the resident's

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response and reason for refusal...the date the physician was notified as well as the physician's response...

A review of the facility's "Medication Administration" policy dated revised 9/2023 included... Report and document ... refusals...

3. The surveyor reviewed the closed medical record for Resident #292.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]

A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a brief interview for mental status (BIMS) score of [redacted] which demonstrated [redacted]

A review of Resident #292's Medication Administration Record (MAR) revealed the following:

An order for Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] topically every day shift for [redacted] care after cleansing with soap and water. The designated space for 11/9/2022 "Day" was blank, with no check mark or nurse's initials.

An order for Exec Order 26, 4b1 NJAC 8:43E-2.1 by mouth one time a day for [redacted] The designated space for 11/9/2022 at 0900 was blank, with no check mark or nurse's initials.

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F 658	Continued From page 15 An order for [redacted] Give 1 tablet by mouth one time a day for [redacted]. The designated space for 11/9/2022 at 0900 was blank, with no check mark or nurse's initials. An order for [redacted] give 1 tablet by mouth one time a day for [redacted] please administer with meal. The designated space for 11/9/2022 at 0900 was blank, with no check mark or nurse's initials. An order for [redacted] Give 1 tablet by mouth one time a day for [redacted] The designated space for 11/9/2022 at 0900 was blank, with no check mark or nurse's initials. An order for [redacted] Give 1 tablet by mouth two times a day for [redacted]. The designated space for 11/9/2022 at 0900 was blank, with no check mark or nurse's initials. An order for [redacted] Give 1 capsule by mouth two times a day for [redacted] The designated space for 11/9/2022 at 0900 was blank, with no check mark or nurse's initials. An order to evaluate [redacted]. The designated space for 11/9/2022 at "DAY" was blank, with no check mark or nurse's initials. An order for [redacted] give 1	F 658		

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capsule by mouth three times a day for [redacted] The designated space for 11/9/2022 at 0900 and 1400 was blank, with no check mark or nurse's initials.

An order to monitor every shift for [redacted] The designated space for 11/9/2022 at "DAY" was blank, with no check mark or nurse's initials.

An order for [redacted] as per sliding scale: if 150-200= 2 unit; 201-250= 4 unit; 251-300= 6 unit; 301-350= 8 unit; 351-400= 10 unit Call MD if [redacted], subcutaneous before meals and at bedtime for [redacted]. The designated space [redacted] 11/9/2022 at 0730 and 1130 was blank, with no check mark or nurse's initials.

On 11/20/2023 at 10:42 AM, the surveyor interviewed Registered Nurse (RN #2), who stated that there should never be a blank space in a MAR. RN #2 continued to state that if a medication was not given then the physician should be contacted and explanation given in rogress notes.

On 11/20/2023 at 11:08 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of Clinical Regional Nurse (CRN), who confirmed the presence of blank spaces throughout the MAR on 11/9/2022. The DON confirmed that there should not be blank spaces on the MAR.

A review the facility's "Documentation Policy/Procedure" Policy, included...1.Pursuant to

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the Police and Procedure for the Interdisciplinary Progress Notes (IPN), all professional disciplines are to document accordingly ... 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR.

A review the facility's "Position Title: Licensed Practical Nurse responsibilities/Accountabilities": documentation, included ... Dispenses medication and performs treatments, as requested, and in accordance with policies and procedures.

4. On 11/13/2023 at 11:37 AM, the Resident #58 was observed in the hallway in their wheelchair.

The surveyor reviewed the medical record for Resident #58.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis that included Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]

A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a brief interview for mental status (BIMS) score of [redacted] which demonstrated [redacted]

A review of the PO identified that Resident #58 was ordered Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] every 12 hours for [redacted] HOLD for [redacted], call MD if [redacted] readings less than [redacted]

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A review of Resident #58's eMar revealed that the resident's [redacted] Underneath the resident's [redacted] a Chart Code of [redacted] was entered that identified [redacted] Underneath the resident's [redacted] results on [redacted] a Chart Code of "5" was entered that identified "Hold/See Nurse Note".

A review of Resident #58's electronic medical record Progress Notes did not document that the resident's physician was contacted to notify of [redacted], as per the PO.

Further review of Resident #58's electronic medical record Progress Notes identified a Plan of Care noted dated [redacted] for an "evaluation [redacted], [status post] ER visit [...] was sent to [emergency room] last night post [redacted] Staff reports [redacted] on floor and was sent to [emergency department] for [redacted] The surveyor did not observe a nursing note documenting the [redacted]

On 11/20/2023 at 10:42 AM, the surveyor interviewed Registered Nurse (RN #2), who confirmed that if a physician sets parameters for a point of care test and the result returned below that number, the physician should be contacted, and a progress note should be entered documenting that conversation. RN #2 stated that after a [redacted] it was the responsibility of the nurse to enter the resident's assessment into the progress notes depicting the events of the incident.

On 11/20/2023 at 11:08 AM, the surveyor interviewed Registered Nurse Unit Manager (RN/UM#2) who stated that if a physician enters

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an order to be contacted with Exec Order 26, 4b1 NJAC 8:43E-2.1 then they were to be contacted and it should be documented under progress note. RN/UM #2 confirmed that there was no documentation of the physician being contacted for the Exec Order 26, 4b1 NJAC 8:43E-2.1 on 1 Exec Order 26, 4b1 NJ and Exec Order 26, 4b1 NJAC RN/UM#2 confirmed that a progress note was required after a Exec O incident, which would include the narrative of the patient, Exec Order 26, 4b1 NJAC 8:43E-2.1, and vital signs.

On 11/20/2023 at 11:08 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of Clinical Regional Nurse (CRN), who stated that physicians were to be contacted when any medication, including Exec Order 26, is withheld. The DON and CRN confirmed that there was no documentation of the physician being contacted for the Exec Order 26, 4b1 NJAC 8:43E-2.1 on Exec Order 26, 4b1 NJAC and Exec Order 26, 4b1 NJAC. The DON and CRN further confirmed that after a resident fall, the nurse was to document the incident in the progress notes because it was a change in patient's status. The DON and CRN confirmed that the Exec O was not documented in Resident #58's electronic medical record.

A review the facility's "Documentation Policy/Procedure" Policy, dated 11/2022, included under policy ... the resident's medical record will reflect- on a continuum- all events that substantiate the effectiveness of (or need for revision in) care planning. Moreover, documentation in the Interdisciplinary Progress Notes must reflect assimilation of communication amongst and between disciplines... 1. Pursuant to the Police and Procedure for the Interdisciplinary Progress Notes (IPN), all professional disciplines are to document accordingly ...2. Documentation

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F 658	Continued From page 20 must address both new positive and negative events ... A review the facility's "Position Title: Licensed Practical Nurse responsibilities/Accountabilities:" documentation, included ... ensures that pertinent information is communicated to and from him/her and orders are taken correctly ... Assesses each resident daily and implements a change in the course of action as needed	F 658		
F 677 SS=E	NJAC 8:39-27.1(a)-29.2(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: Complaint # NJ 154800, NJ 154946, NJ 158378 Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to a.) ensure that [redacted] was provided to dependent residents in a timely manner for 7 of 9 residents (Resident #3, #25, #103, #75, #48, #95, and #127) observed for [redacted] and b.) provide nail care to residents that required [redacted] for 2 of 4 residents, (Resident #127 and #75) reviewed for ADLs. This deficient practice was evidenced by the following:	F 677	I. - Residents #3 was provided with proper [redacted] immediately. Frequent rounds in place to ensure [redacted] provided regularly and as needed to prevent infections/body odors and to restore [redacted] to the extent possible. - Resident #25's [redacted] was removed and proper [redacted] provided immediately. Frequent rounds in place to ensure [redacted] provided regularly and as needed to prevent infections/body odors and to restore [redacted] to the extent possible. - Resident #103's [redacted] was removed and proper [redacted] provided immediately. Frequent rounds in	12/31/23

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F 677	Continued From page 21 1. On 11/15/23 at 12:46 PM, during an interview with the surveyor, RN/UM #2 and LPN #2 identified residents as being NJ Exec. Order 26:4.b.1 staff for care. On 11/16/23 at 7:36 AM, the surveyor completed an Exec Order 26, 4b1 NJAC 8:43 tour on the NJ Exec. Order 26:4.b.1 and observed the following: a. On 11/16/23 at 8:00 AM, the surveyor accompanied by Registered Nurse (RN) #2 observed Resident #3 in bed. The surveyor observed that Resident #3's Exec Order 26, 4b1 NJAC 8:43E-2.1 was Exec Order 26, 4b1 NJAC 8:43E-2.1 Licensed Practical Nurse (LPN) #1 entered the room to assist RN #2 who both acknowledged the Exec Order 26, 4b1 NJAC 8:43E-2.1 A review of Resident #3's Admission Record reflected that the Resident was admitted to the facility with diagnoses which included but were not limited to Exec Order 26, 4b1 NJAC 8:43E-2.1 A review of Resident #3's Admission Minimum Data Set (MDS) an assessment tool dated Exec Order 26 revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of Exec Order 26, 4b1 NJAC 8 which indicated Resident #3 had Exec Order 26, 4b1 NJAC 8:43E-2.1 The MDS further revealed that the resident was dependent on staff for personal hygiene, and he/she was always Exec Order 26, 4b1 NJAC 8:43	F 677	place to ensure Exec Order 26, 4b1 NJAC 8:43E-2.1 provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #75 was provided with Exec Order 26, 4b1 N as well as nail care immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8:43E-2.1 provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #48 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8 provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #95 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8 provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #127 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Resident was provided with nail care, using skin moisturizing lotion for dry skin immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8:43E-2.1 provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. II. - All residents have the potential to be affected by the same deficient practice. III. - All residents with Exec Order 26, 4b1 NJAC 8:43E-2.1 will	

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F 677	Continued From page 22 b. On 11/16/23 at 8:22 AM, the surveyor accompanied by LPN #2 observed Resident #25 in bed. CNA #1 was in the resident's room and exposed Resident #25's Exec Order 26, 4b1 NJAC 8:43E-2.1 t that time when CNA #1 exposed the Exec Order 26, 4b1 NJAC 8:43E-2.1 another Exec Order 26, 4b1 NJAC 8:43E-2.1 was observed which also Exec Order 26, 4b1 NJAC 8:43E-2.1. The pad under the Exec Order 26, 4b1 NJAC 8:43E-2.1 used to protect the bed sheets also was Exec Order 26, 4b1 NJAC 8:43E-2.1. LPN #2 and CNA #1 both acknowledged the two Exec Order 26 and pad were Exec Order 26, 4b1 NJAC 8:43E-2.1 and they each stated that no residents should be wearing two Exec Order 26, 4b1 NJAC 8:43E-2.1 A review of Resident #25's Admission Record revealed Resident #25 was admitted to the facility with diagnoses which included but not limited to Exec Order 26, 4b1 NJAC 8:43E-2.1 A review of Resident #25's Quarterly MDS dated Exec Order 26, 4b1 revealed Resident #25 had a BIMS of Exec indicating Exec Order 26, 4b1 NJAC 8:43E-2.1 MDS further assessed Resident #25 was dependent on staff for personal hygiene and was frequently Exec Order 26, 4b1 NJAC 8:43E-2.1 c. On 11/16/23 at 8:30 AM, the surveyor accompanied by LPN #2 observed Resident #103 in bed. LPN #2 exposed Resident #103's brief which was Exec Order 26, 4b1 NJAC 8:43. At that time, when LPN #2 exposed the Exec Order 26, 4b1 NJAC 8:43E-2.1 the surveyor observed another Exec Order 26, 4b1 NJAC 8:43E-2.1 in place which was also Exec Order 26, 4b1 NJAC 8:43E LPN#2 stated that the resident's should not have two Exec Order 26, 4b1 NJAC 8 in place. A review of Resident #103's admission record	F 677	be checked for double diapering and proper/timely incontinence care. - All residents will be checked for cleanliness and good condition of nails. - DON/Designee will re-train all direct care as well as nursing staff on facility ADL Care policy and procedures to ensure that all residents requiring such assistance provided with ADL care, including no double diapering and changing the residents every two hours and as needed. - All nursing staff will provide ADL care to all residents based on facility ADL care policy and procedures to ensure all ADL needs are met on a daily basis, including no double diapering and changing the residents every two hours and as needed. - DON/Designee will re-train all direct as well as nursing staff on facility Nail Care and Foot Care policy and procedures to ensure residents receive proper nail care and foot treatment to provide cleanliness of nails and to promote good condition of nails and skin. - ALL nursing staff will provide nail care to all residents to provide cleanliness of nails and to promote good condition of nails; nails will be cleaned daily and filed weekly or as necessary to keep nails clean. The nursing staff instructed on procedure will provide observation and care of nails. IV. - Unit Managers/Designee will conduct daily random checks/audits of the nursing incontinence care in all units to ensure that nursing staff do not have double diapering while providing incontinence care and all residents are provided with	

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F 677	Continued From page 23 reflected Resident #103 was admitted to the facility with diagnoses which included but were not limited to Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] A review of Resident #103's Quarterly MDS dated Exec Order 26, 4b revealed Resident #103 had a BIMS score of Exec Order 26, 4b1 NJ which indicated the Resident had a Exec Order 26, 4b1 NJAC 8:43E-2.1 The MDS further reflected that Resident #103 required moderate assistance from staff for personal hygiene, was frequently Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] d. On 11/16/23 at 8:42 AM, the surveyor accompanied by RN/UM # 2 observed Resident #75 in bed, with the resident's permission the RN/UM asked to check the Exec Order 26, 4b1 NJAC 8:43E-2.1 which was Exec Order 26, 4b1 NJAC 8:43E-2.1 Resident #75 stated, Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] A review of Resident #75's Admission Record revealed Resident #75 was admitted to the facility with diagnoses that included but were not limited to Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] A review of Resident #75's Quarterly MDS dated Exec Order 26, 4b1 revealed Resident #75 had a BIMS score of Exec Order 26, 4b1 NJ which indicated that the resident was Exec Order 26, 4b1 NJAC 8:43E-2.1. The MDS further reflected that Resident #75 required staff assistance for personal hygiene and was Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]	F 677	incontinence care every two hours and/or as needed. - DON/Designee will conduct random audits through nursing rounds/observations of all residents' ADL care to ensure that all ADL daily needs are met and all ADL care provided. Results will be recorded in the incontinence tracking sheet; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - DON/Designee will will conduct random audits of all residents' nail/foot care to ensure that nail care and foot care/treatment are provided and results recorded in the audit tracking sheet; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meetings for the next six (6) months for review and revision as deemed appropriate.	

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e. On 11/16/23 at 8:52 AM, the surveyor accompanied by LPN #1 observed Resident #48 in bed. LPN #1, with the resident's permission exposed the [redacted] which was [redacted] LPN #1 stated, [redacted]

A review of Resident #48's Admission Record revealed Resident #48 was admitted to the facility with diagnoses which included but were not limited to [redacted]

A review of Resident #48's Quarterly MDS dated [redacted] reflected that Resident #48 had a BIMS of [redacted] which reflected Resident #48 had a [redacted] The MDS further revealed the Resident required maximum assistance from staff for personal hygiene and was always [redacted]

f. On 11/16/23 at 9:44 AM, the surveyor accompanied by CNA #2 observed Resident #95 in bed, unclothed, and observed their [redacted] on the floor and was be [redacted] CNA #2 stated that he had just removed Resident #95's [redacted]. The surveyor asked CNA #2 if it was acceptable to place the [redacted] on the floor. CNA #2 replied, "You're just trying to make my job difficult." At that time, the Director of Nursing (DON) entered Resident #95's room and observed the [redacted] on the floor. The DON told CNA #2 that the [redacted] should not be on the floor. At that time, the DON stated to the surveyor that [redacted] rounds should be completed every two hours, and that the above observations were unacceptable.

A review of Resident 95's Admission Record

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revealed that Resident #95 was admitted to the facility with diagnoses which included but were not limited to Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]

The Admission MDS dated Exec Order 26, 4b1 NJAC 8:43E-2.1 revealed Resident #95's cognitive skills for daily decision-making were Exec Order 26, 4b1 NJAC 8:43E-2.1 The MDS further assessed Resident #95 required assistance from staff for personal hygiene and was always Exec Order 26, 4b1 NJAC 8:43E-2.1

g. On 11/20/23 at 10:10 AM, the surveyor accompanied by CNA #5 observed Resident #127 in bed. CNA #5 asked Resident #127 is she could check his/her Exec Order 26, 4b1 NJAC 8:43E-2.1 and the resident nodded their head. Resident #127 was wearing an Exec Order 26, 4b1 NJAC 8:43E-2.1 which was Exec Order 26, 4b1 NJAC 8:43E-2.1. CNA #5 acknowledged the resident's [redacted] was Exec Order 26, 4b1 NJ. CNA #5 stated that it was the first chance she got to do Exec Order 26, 4b1 NJAC 8 [redacted]

A review of the Admission record reflected Resident #127 was admitted to the facility with diagnoses that included but were not limited to: Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted]

A review of the Quarterly MDS dated Exec Order 26, 4b [redacted] revealed Resident #127 had short-term and long-term Exec Order 26, 4b1 NJAC 8:43E-2.1 and that their cognitive skills for daily decision-making were Exec Order 26, 4b1 NJAC 8:43E-2.1 Further review of the MDS revealed that the resident required extensive assistance from staff for personal hygiene and was always Exec Order 26, 4b1 NJAC 8:43E-2.1

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F 677	Continued From page 26 During an interview with the surveyor on 11/16/23 at 10:28 AM, CNA #3 stated that she completed [Exec Order 26, 4b1 NJAC 8] rounds every 2 hours starting at 7:00 AM, and continued all day long. CNA #3 stated that she never used double [Exec Order 2] because it could cause rashes and infections. During an interview with the surveyor on 11/16/23 at 10:31 AM, CNA #1 stated that she completes [Exec Order 26, 4b1 NJAC 8] rounds on the residents every two hours and never used two [Exec Order 26] at one time. CNA #1 stated that she always did her last [Exec Order 26, 4b1 NJAC 8:43E-2.1] rounds at 2:30 PM. During an interview with the surveyor on 11/17/23 at 7:14 AM, CNA #4 stated that she completed [Exec Order 26, 4b1 NJAC 8] rounds every two hours and never put two [Exec Order 26] on the resident at the same time. The assigned 11 PM-7 AM CNAs (CNA #6, #7, and #8) for Resident's #3, #25, #103, #75, #48, #95, and #127 were unavailable to be interviewed. A review of the facility's [Exec Order 26, 4b1 NJAC 8:43E-2.1] policy reflected...based on the resident's comprehensive assessment, all residents who are [Exec Order 26, 4b1 NJAC] will receive appropriate treatment and services...to prevent infections and to restore [Exec Order 26, 4b1 NJAC] to the extent possible. 2. On 11/16/23 at 8:42 AM the surveyor observed Resident #75 in bed. The surveyor observed the resident's fingernails to be [NJ Exec. Order 26:4.b.1] . Resident #75 stated they would like to have their nails cleaned and trimmed. On 11/17/23 at 7:14 AM, the surveyor and CNA	F 677		

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F 677	Continued From page 27 #4 observed Resident #75's fingernails appeared to be NJ Exec. Order 26:4.b.1 . Resident #75 stated Exec Order 26, 4b1 NJAC 8:43E-2.1 [redacted] On 11/20/23 at 10:10 AM, the surveyor accompanied by CNA #5 observed Resident #127 in bed. With the resident's permission, CNA #5 removed the sheet and exposed Resident #127's feet. Their toenails appeared to be [redacted] CNA #5 stated that she had told a nurse a long time ago that the resident's nails needed to be clipped but could not recall which nurse she had told. A review of the facility's policy "ADL care" with a revised date of 9/2023, reflected: It is the policy of this facility to provide ADL care to residents requiring such assistance to ensure all ADL needs are met on a daily basis. A review of the facility policy, "Nail Care" with a revised date of 9/2023, indicated...Nails will be cleaned daily and filed weekly or as necessary to keep nails clean. The nursing staff instructed on procedure will provide observation and care of nails. On 11/21/23 at 1:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant LHNA, Regional DON, Regional Infection Preventionist Nurse (RIPN), and DON to discuss the above observations and concerns. The DON stated that the podiatrist came to the facility every 90 days and the nurses and CNAs were responsible for putting the residents on the list to ensure those residents who needed to be seen would be seen. The DON	F 677		

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F 677	Continued From page 28 further stated that the CNAs should be applying lotion to residents feet daily and fingernails should be cleaned and trimmed during care. On 11/22/23 at 9:33 AM, no further information was provided by the facility. NJAC 8:39-27.1 (a), 27.2 (h)	F 677		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to consistently complete the [NJ Exec. Order 26] communication form for one (1) of two (2) residents, (Resident # 239) reviewed for [NJ Exec. Order 26] This deficient practice was evidenced by the following: On 11/17/23 at 10:01 AM, the surveyor observed the resident seated in a wheelchair in their room. Resident #239 stated that he/she goes to [Exec Order 26, 4] on Mondays, Wednesdays, and Fridays. A review of Resident #239's admission record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: Exec Order 26, 4b1 NJAC 8:43E-2.1	F 698	I. - For Resident #239, the facility nurse called the [Exec Order 26, 4] center to request missing information in the [Exec Order 26, 4b1 NJAC 8:43] Communication Record book; all sections were completed immediately. II. - All residents have the potential to be affected by the same deficient practice. III. - All dialysis communication books for the current residents on dialysis will be checked to ensure that the communication form is fully filled out in order to follow recommendations if any. - DON/Designee will re-train all nursing staff, including direct care staff on facility	12/31/23

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F 698	Continued From page 29 [redacted] A review of the Admission Minimum Data Set (MDS), an assessment tool dated [redacted] reflected a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated an [redacted]. A further review of the resident's MDS, Section O - Special Treatment and Procedures, reflected that the resident received [redacted] services [redacted] A review of the resident's individualized Care Plan revised on [redacted], reflected that Resident #239 was at risk for complications related to [redacted] A further review of the care plan revealed the intervention was to communicate with the [redacted] regarding medications, diet, and lab results; to coordinate care in collaboration with the resident's [redacted] center. A review of the November 2023 Order Summary Report revealed that Resident #239 had active physician orders for the following: [redacted] On 11/17/23 at 9:39 AM, the surveyor reviewed Resident #239's [redacted] Communication Record (HDCR) book which was located at the nurses' station. A review of the resident's HDCR book revealed	F 698	Dialysis policy and procedure to ensure that all sections of the communication book are filled out by the dialysis and facility staff. - All nursing staff will follow facility Dialysis policy and procedures to ensure that upon return from dialysis, the communication form is fully filled out in order to follow recommendations if any. IV. - Unit Managers/Designee will conduct audits of all residents on dialysis on completion of the dialysis communication form to ensure that all sections are filled out by the dialysis nurse and reviewed by the facility nurse to follow recommendations if any, results of audits will be recorded into the audit sheet; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - DON/Designee will conduct spot audits on completion of the dialysis communication form to ensure that all sections are filled out by the dialysis nurse and reviewed by the facility nurse to follow recommendations if any, results of audits will be recorded into the audit sheet; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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individual forms that contained three separate sections to be filled out: the top section - to be completed by center licensed nurse for [redacted] patient prior to [redacted] treatment, the middle section - to be completed by [redacted] nurse following [redacted] treatment and to accompany patient on return to center post - [redacted], and the bottom section to be completed by center licensed nurse post - [redacted] treatment. A further review of the [redacted] forms reflected that the forms from [redacted] revealed the middle section was not consistently filled out and the bottom section was not filled out on [redacted]

On [redacted] the surveyor interviewed Resident #239 who stated upon arrival from [redacted] the nurses assessed him/her. The resident stated the nurses checked his/her [redacted] and checked their [redacted].

During an interview with the surveyor on 11/20/23 at 10:15 AM, the RN/UM stated that the nurse at the facility was responsible for filling out the top section of the [redacted] and the [redacted] center was responsible for completing the middle section and the facility nurses were responsible for filling out the bottom section of the [redacted]. She further stated that if the [redacted] center did not complete the middle section, then the nurses should follow up with the [redacted] center to get a report.

On 11/21/23 at 1:35 PM, the survey team met with the Administrator, Assistant Administrator, and Director of Nursing (DON) to discuss the above observations and concerns. The DON stated that the [redacted] center should be filling out their section prior to the resident leaving the [redacted] center. The DON then stated that if the [redacted] center did not complete their section, the

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F 698	Continued From page 31 expectation of the nurses would be to call the [Exec Order 26, 4] center for a report. A review of the facility's policy, [Exec Order 26, 4b1 NJ] revised 9/2023 included ... the following information will be documented in the resident's medical record: Monitoring for complications related to [Exec Order] monitoring for signs and symptoms of infection, monitoring for patency of [Exec Order 26, 4] access, measures to protect [Exec Order 26, 4] access ...A [Exec Order 26, 4] communication form will be sent with the resident to [Exec Order 26, 4]. Upon return from [Exec Order 26, 4], the charge nurse will review and take note of any recommendations. NJAC 8:39-27.1(a)	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		12/31/23

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F 725	Continued From page 32 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint #NJ00155975; NJ00158378; NJ00154946; NJ154800 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to provide adequate staff to ensure all residents were provided with timely: a.) Exec Order 26, 4b1 NJAC 8:43E-2.1 and b.) nail care for residents that required extensive assistance for activities of daily living (ADLs). This deficient practice occurred for 7 of 9 residents reviewed for Exec Order 26, 4b1 NJAC 8:43E-2.1 (Resident #3, #25, #103, #75, #48, #95 and #127 on 2 of 4 units Exec Order 26, 4b1 NJAC 8:43E-2.1 and for 2 of 4 residents, (Resident #38 and #218) reviewed for ADLs and was evidenced by the following: Refer to F677E Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 nursing homes. The following ratio(s) were effective on 2/01/21:	F 725	I. - Residents #3 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8 care provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #25 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8 care provided regularly and as needed to prevent infections/body odors and to restore NJ Exec. Order 26:4.b.1 to the extent possible. - Resident #103 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8 care provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #75 was provided with Exec Order 26, 4b1 N as well as nail care immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8 care provided regularly and as needed to prevent infections/body odors and to restore Exec Order 26, 4b1 NJAC to the extent possible. - Resident #48 was provided with Exec Order 26, 4b1 NJAC 8:43E immediately. Frequent rounds in place to ensure Exec Order 26, 4b1 NJAC 8:43	

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F 725	Continued From page 33 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. The surveyor reviewed the staffing for dates 10/29/2023 through 11/11/2023 which revealed that the facility was deficient in Certified Nursing Assistant (CNA) staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 5 of 14 evening shifts as follows: -10/29/23 had 7 CNAs for 142 residents on the day shift, required at least 18 CNAs -10/29/23 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -10/30/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -10/31/23 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/01/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/02/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/03/23 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/04/23 had 10 CNAs for 147 residents on the day shift, required at least 18 CNAs.	F 725	care provided regularly and as needed to prevent infections/body odors and to restore [redacted] to the extent possible. - Resident #95 was provided with [redacted] immediately. Frequent rounds in place to ensure [redacted] care provided regularly and as needed to prevent infections/body odors and to restore [redacted] to the extent possible. - Resident #127 was provided with [redacted] immediately. Resident was provided with nail care, using skin moisturizing lotion for dry skin immediately. Frequent rounds in place to ensure [redacted] care provided regularly and as needed to prevent infections/body odors and to restore [redacted] to the extent possible. II. - All residents have the potential to be affected by the same deficient practice. III. - Administrator/HR/Designee will re-educate all nursing staff on facility Attendance policy and procedures, including call out policy. - DON/Staffing Coordinator/Assistant Administrator will meet daily to review all callouts and proactively make every effort to replace and /or substitute staff members. - The facility has implemented a competitive market rate for the Nurses and the Certified Nursing Assistants (CNAs); additional Temporary Incentive Bonus for the CNAs is in place; additional Bonus structure for nurses and CNAs is in	

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F 725	Continued From page 34 -11/05/23 had 9 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/05/23 had 6 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -11/06/23 had 9 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/07/23 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/07/23 had 9 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -11/08/23 had 11 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/09/22 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/09/23 had 11 CNAs to 24 total staff on the evening shift, required at least 12 CNAs. -11/10/23 had 10 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/11/23 had 9 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/11/23 had 8 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. On 11/16/23 at 7:36 AM, surveyor #1 conducted an Exec Order 26, 4b1 NJAC 8: tour on the NJ Exec. Order 26:4.b.1. The surveyor was accompanied by one Licensed Practical Nurses (LPN) one Registered Nurses (RN) one Registered Nurse Unit Manager (RN/UM) and eight CNAs during the tour of nine residents for Exec Order 26, 4b1 NJAC 8:43 care. Of the nine residents the surveyor observed, seven (Resident #3, #25, #103, #75, #48, #95 and #127) were found with saturated Exec Order 26, 4b1 NJAC 8:43E-2.1 as well as multiple instances of double Exec Order 26, 4b1 NJAC 8:43E-2.1 On 11/16/23 at 9:27 AM, surveyor #2 interviewed RN/UM on Millstone Unit who stated there were	F 725	place to incentivize weekend nursing staff. - Facility Master Schedule is in place and updated real time to match with ADP payroll system; each CNA has ADP app on the phone to be aware of the scheduled shifts to comply with attendance for scheduled working hours. - Facility will continue to hire Per Diem licensed nursing staff to cover the shifts in any case of call outs. - Administrator, Director of Nursing and Staffing Coordinator are meeting every morning to discuss staffing schedule for the day and following 3-5 days. - Facility has 24-hour nursing management on-call rotation in case of any call outs and/or to cover the floor if needed. - Facility utilizes reinforcement steps for excessive call outs if any. IV. - Administrator/DON/Designee will monitor ratios weekly until requirements are met; the results of the audits will be forwarded to the facility Administrator and monthly QAPI Committee for review and revision as deemed appropriate; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed.. - The Human Resources Director/Designee will report recruitment and retention trends, outcomes, and recommendations to the Quality Assurance and Performance Improvement Committee meetings monthly x 5 months. - Results of the	

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F 725	Continued From page 35 two nurses, and two Certified Nurse Aides (CNA) working that day and the unit census was 27. This far exceeds the minimum staffing requirements required. On 11/16/23 at 8:42 AM, surveyor #1 observed Resident #75 in bed. Surveyor #1 observed the resident's fingernails were long and soiled underneath. Resident #75 stated [redacted] On 11/20/23 at 10:10 AM, surveyor #1 along with a CNA observed Resident #127's feet, their toenails appeared [redacted] On 11/21/23 at 10:07 AM, surveyor #2 interviewed the facility staffing coordinator (SC) who stated she was aware of the minimum staffing requirements. The SC stated right now the facility met the staffing requirements but that ratios would change with staff call outs. On 11/22/23 the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team, stated she was aware of the minimum staffing requirements and were currently in the process of hiring more staff. A review of the facility "Nursing Services and Sufficient Staff" policy revised 9/2023 included... It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident...The facility will supply services by sufficient numbers... licensed nurses...including but not limited to nurse aides.	F 725	audits will be presented to the monthly QAPI meetings for five (5) months and as needed for review and revision as deemed appropriate.	

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F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage compactor free of garbage and debris. On 11/13/23 at 9:59 AM, the surveyor, in the presence of the Food Service Supervisor (FSS) toured the kitchen and the designated garbage area and observed the following: There was garbage debris that included food, gloves, cups, paper products, plastic bags, and card board surrounding the garbage compactor. The FSS stated that the area should have been clean by the maintenance, housekeeping, and dietary departments. On 11/20/23 at 2:19 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and was informed of the findings. The LNHA stated the garbage compactor was replaced prior to survey and the maintenance department and housekeeping should ensured the area was clean. A review of the facility policy titled "Dispose of Garbage and Refuse," dated 8/17, indicated that the Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster's is maintained in a manner free of rubbish and debris.	F 814	I. - All garbage debris, including food, gloves, cups, paper products, plastic bags and card board surrounding the garbage compactor were cleaned immediately. II. All residents have the potential to be affected by the same deficient practice. III. - Food Service Director (FSD)/Designee will re-train all kitchen/housekeeping/maintenance staff on facility Garbage Disposal policy and procedures to ensure that the area surrounding the exterior dumpster is maintained in a manner free of rubbish and debris. - All staff involved in the garbage disposal, including kitchen/housekeeping/maintenance staff will ensure that the area surrounding the exterior dumpster remains free of rubbish and debris after disposal of the garbage. IV. - Food Service Director/Maintenance Director/Designee will conduct random audits of the area surrounding dumpster to ensure it stays free of rubbish and debris. Result of the audits will be recorded in the audit tracking form; audits	12/31/23

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F 814	Continued From page 37 NJAC 8:39-19.3(ac)	F 814	will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for next six (6) months for review and revision as deemed appropriate.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		12/31/23

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F 880	Continued From page 38 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	I.	

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F 880	Continued From page 39 and review of facility documentation, it was determined that the facility failed to maintain infection control standards and procedures to address the risk of infection transmission by failing to: a.) follow appropriate hand hygiene practices for 4 of 5 staff observed and b.) handle and store linens and resident's garbage in accordance with facility policy. This deficient practice was evidenced by the following: 1. On 11/13/23 at 1:50 PM, the surveyor observed Registered Nurse (RN) #1 don (put on) a disposable gown, and gloves and entered room [redacted] which had signage indicating the resident was on NJ Exec. Order 26:4.b.1 . On 11/13/23 at 1:55 PM, the surveyor observed RN #1 preparing to exit room [redacted], RN #1 doffed (took off) her gown and gloves and exited the room. The surveyor observed that RN #1 did not sanitize or wash her hands after she removed her gloves. On 11/16/23 at 7:57 AM, during [redacted] rounds, the surveyor observed RN #2 enter room [redacted], and checked the resident's [redacted] Afterward, the surveyor observed RN #2 washed her hands for 5 seconds before placing her hands under the stream of water. RN #2 then used the same paper towel that she dried her hands with and turned off the faucet. On 11/16/23 at 8:00 AM, RN #2 entered room [redacted] during [redacted] rounds and checked the resident's [redacted] Afterward, the surveyor observed RN #2 washed her hands for 13 seconds before placing her hands under the	F 880	- All unit nursing staff were re-educated on facility Hand Hygiene policy and procedures with completing hand wash competency immediately. - The CNA #2 was suspended immediately. II. - All residents have the potential to be affected by the same deficient practice. III. - Infection Preventionist (IP)/Designee will re-educate all facility staff on facility Hand Hygiene policy and procedures. - All facility staff involved in direct resident contact will complete the hand hygiene competency; all will be recorded in the hand hygiene validation form. - IP will complete in-service for newly hired employees on facility Hand Hygiene policy as well as hand hygiene competency as a part of onboarding upon hiring. - All facility staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. IV. - Infection Preventionist (IP)/Designee will have surveillance in place to ensure effective implementation of hand hygiene practices by all departments to prevent spread of infections. - IP/Designee will conduct spot checks of the staff involved in direct resident contact on proper hand hygiene procedures to	

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F 880	Continued From page 40 stream of water. RN #2 then used the same paper towel that she dried her hands with and turned off the faucet. On 11/16/23 at 8:13 AM, during [redacted] rounds the surveyor observed RN #2 entered room [redacted]. Afterward, RN #2 washed her hands for 13 seconds before placing her hands under the stream of water. RN #2 then used the same paper towel that she dried her hands with and turned off the faucet. On 11/16/23 at 8:22 AM, Licensed Practical Nurse (LPN) #2 entered room [redacted] and checked the resident's [redacted] Afterward, LPN #2 washed her hands for 12 seconds before placing her hands under the stream of water. On 11/16/23 at 8:25 AM, LPN #2 entered room [redacted] and checked the resident's [redacted]. Afterward, LPN #2 washed her hands for 5 seconds before placing her hands under the stream of water. On 11/16/23 at 8:30 AM, LPN#2 entered room [redacted] and checked the resident's [redacted] Afterward, LPN#2 washed her hands for 11 seconds before placing her hands under the stream of water. On 11/16/23 at 8:42 AM, during [redacted] care rounds, the surveyor observed the Registered Nurse/Unit Manager (RN/UM) #2 entered room [redacted] and checked the resident's [redacted] Afterward, the surveyor observed the RN/UM #2 wash her hands for 9 seconds before placing her hands under the stream of water. During an interview with the surveyor on 11/16/23	F 880	prevent the spread of infection to other personnel, residents and visitors; spot checks will be conducted weekly X 4 weeks - 4 spot checks, bi-weekly X 4 weeks - 2 spot checks, then monthly for next three months - 3 spot checks, and as needed. - IP/Designee will report all instances of noncompliance with established infection control practices, including hand hygiene, if any, to the Administrator and to appropriate department heads or supervisors; such instances, if any, will be recorded in the infection control report. - DON/Designee will conduct spot check audits on proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors; spot check audits will be conducted weekly X 4 weeks - 4 spot check audits, bi-weekly X 4 weeks - 2 spot check audits, then monthly for next three months - 3 spot check audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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F 880	Continued From page 41	F 880		

at 1:30 PM, RN #2 stated that the process for handwashing included lathering hands together with soap for 15-20 seconds and the entire handwashing process should take one to two minutes.

During an interview with the surveyor on 11/16/23 at 1:35 PM, LPN #2 stated that the process for handwashing included lathering hands together and that the entire process should take 20 seconds. The surveyor showed LPN #2 the handwashing instructions that were hanging on the wall which instructed to scrub hands for 20 seconds. LPN #2 acknowledged that she should wash her hands with soap for 20 seconds before placing her hands under the stream of water.

On 11/17/23 at 7:14 AM, the surveyor observed Certified Nursing Assistant (CNA) #4 enter room [redacted] and the surveyor observed CNA #4 wash her hands for 9 seconds before placing her hands under the stream of water. CNA #4 applied gloves, provided care to the resident and afterward, the surveyor observed CNA #4 removed her gloves and washed her hands for 8 seconds before placing her hands under the stream of water.

During an interview with the surveyor on 11/17/23 at 7:19 AM, CNA #4 stated that the process for handwashing included lathering hands together for 20 seconds before placing them under the stream of water. CNA #4 further stated that the reason she didn't lather her hands for 20 seconds was that she was "rushing."

During an interview with the surveyor on 11/17/23 at 7:22 AM, the RN/UM #2 acknowledged that the process for handwashing included lathering

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	315001	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	100 PLAINSBORO ROAD PLAINSBORO, NJ 08536

(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 880	Continued From page 42	F 880		

hands together for 20 seconds before placing them under the stream of water.

During an interview with the surveyor on 11/21/23 at 9:31 AM, the RN #1 stated that she usually washed or sanitized her hands after she removed her gloves but that she must have been so focused on finding out when the resident's labs were going to be drawn that she forgot to lather for the full 20 seconds.

2. On 11/16/23 at 9:44 AM, the surveyor accompanied by CNA #2 observed Resident #95 in bed, unclothed, and observed their [redacted] on the floor which appeared to be [redacted]. The surveyor also observed two large clear plastic bags, one contained soiled gowns and linens and the other contained trash. CNA #2 stated that he had just removed Resident #95's [redacted]. The surveyor asked CNA #2 if it was acceptable to place the [redacted], a bag of soiled gowns and linen, and a bag of trash on Resident #95's floor. CNA #2 replied, "You're just trying to make my job difficult." At that time, the Director of Nursing (DON) entered Resident #95's room and observed the [redacted], bag of soiled laundry, and bag of trash on the floor. The DON told CNA #2 that the [redacted], bag of soiled laundry, and bag of trash should not be in the resident's room on the floor.

On 11/21/23 at 1:35 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Assistant LHNA, Regional DON, Regional Infection Preventionist Nurse (RIPN), and DON to discuss the above observations and concerns. The DON stated that the staff should be washing their hands for 20 seconds before

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	315001	A. BUILDING _____ B. WING _____	C 11/22/2023

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F 880	Continued From page 43	F 880		

placing hands under the stream of water.

A review of the facility's Hand Hygiene policy, revised 9/22 reflected ...Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors ... Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR) ...staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice ... Hand hygiene technique when using soap and water: Rub hands together vigorously for at least 20 seconds, away from the stream of water and covering all surfaces of the hands and fingers; use single-use towel to turn off the faucet.

A review of the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Clean Hands Count for Healthcare Providers, reviewed 1/8/2021, included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry."

A Review of the facility's Infection Prevention and Control Program policy revised 5/19/23 included ...the facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections ...hand hygiene shall be

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	315001	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 44 performed in accordance with our facility's established hand hygiene procedures ...soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. NJAC 8:39-27.1 (a); NJAC 8:39:19.4 (a)(n)	F 880		

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	11103L	A. BUILDING: _____ B. WING _____	C 11/22/2023

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S 000	Initial Comments Complaint # 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: Complaint # NJ 153361, NJ 154800, NJ 154975, NJ 154946, NJ 155276, NJ 158378 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	I. - Facility hired a new Director of Human Resources who is starting on [redacted NJ Exec. Order 26:4.b.1] - Facility utilizes a Corporate Recruiter (CP) who is scouting through the local CNA schools to recruit newly graduated certified nursing assistants. - Facility is aggressively hiring nursing staff to meet State staffing requirements. - Facility facilitates Open House/Job Fair events as scheduled. - Facility CP collaborates with representative(s) from two Certified Nursing Assistant/LPN vocational schools in the area to recruit graduated CNAs with	12/31/23

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

Electronically Signed | 12/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 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 nursing homes. The following ratio(s) were effective on 2/01/21: 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. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 10/29/23 and 11/5/23 revealed the facility was deficient in CNA staffing for residents as follows: For the 2 weeks of staffing prior to survey from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 5 of 14 evening shifts as follows: -10/29/23 had 7 CNAs for 142 residents on the day shift, required at least 18 CNAs. -10/29/23 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -10/30/23 had 10 CNAs for 142 residents on the	S 560	further job placement at the facility. - Facility has additional Indeed Account to advertise all in-house nursing openings, including Certified Nursing Assistant (CNA) positions. - Facility implemented weekly temporary incentive bonus structure to increase overall CNA's rate to the competitive market level. - Facility implemented aggressive advertisement of the open nursing positions, including job fairs with immediate interviews and contingency offers for all licensed nursing staff, including CNAs. - Facility implemented shift differential pay structure for 3-11 and 11-7 shifts. - Facility implemented signed-on bonus for the CNAs to attract and retain candidates. II. - All residents have the potential to be affected by the deficient practice. III. - Administrator/HR/Designee will re-educate all facility staff on facility Attendance policy and procedures, including call out policy. - DON/Staffing Coordinator/Assistant Administrator will meet daily to review all callouts and proactively make every effort to replace and /or substitute staff members. - The facility has implemented a competitive market rate for the Nurses and the Certified Nursing Assistants (CNAs); additional Temporary Incentive Bonus for the CNAs is in place; additional Bonus structure for nurses and CNAs is in	

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S 560	Continued From page 2 day shift, required at least 18 CNAs. -10/31/23 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/01/23 had 10 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/02/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/03/23 had 9 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/04/23 had 10 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/05/23 had 9 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/05/23 had 6 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -11/06/23 had 9 CNAs for 147 residents on the day shift, required at least 18 CNAs. -11/07/23 had 13 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/07/23 had 9 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -11/08/23 had 11 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/09/22 had 12 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/09/23 had 11 CNAs to 24 total staff on the evening shift, required at least 12 CNAs. -11/10/23 had 10 CNAs for 144 residents on the day shift, required at least 18 CNAs. -11/11/23 had 9 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/11/23 had 8 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. On 11/21/23 at 10:07 AM, the Staffing Coordinator stated that they were aware of the staffing ratio requirements.	S 560	place to incentivize weekend nursing staff. - Facility Master Schedule is in place and updated real time to match with ADP payroll system; each CNA has ADP app on the phone to be aware of the scheduled shifts to comply with attendance for scheduled working hours. - Facility will continue to hire Per Diem licensed nursing staff to cover the shifts in any case of call outs. - Administrator, Director of Nursing and Staffing Coordinator are meeting every morning to discuss staffing schedule for the day and following 3-5 days. - Facility has 24-hour nursing management on-call rotation in case of any call outs and/or to cover the floor if needed. - Facility utilizes reinforcement steps for excessive call outs if any. IV. - DON/Designee will monitor/audit ratios until requirements are met; the results of the audits will be forwarded to the facility Administrator and monthly QAPI Committee for review and revision as deemed appropriate; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - The Human Resources Director/Designee will report recruitment and retention trends, outcomes, and recommendations to the Quality Assurance and Performance Improvement Committee meetings monthly x 3 months, then quarterly x 9 months for review and revision as deemed appropriate.	

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	11103L	A. BUILDING: _____ B. WING _____	C 11/22/2023

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315001 Y1	A. Building B. Wing Y2	1/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	100 PLAINSBORO ROAD PLAINSBORO, NJ 08536

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	F0609	Correction	ID Prefix	F0656	Correction	ID Prefix	F0658	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.21(b)(1)(3)	Completed	Reg. #	483.21(b)(3)(i)	Completed
LSC		12/15/2023	LSC		12/31/2023	LSC		12/31/2023
ID Prefix	F0677	Correction	ID Prefix	F0698	Correction	ID Prefix	F0725	Correction
Reg. #	483.24(a)(2)	Completed	Reg. #	483.25(l)	Completed	Reg. #	483.35(a)(1)(2)	Completed
LSC		12/31/2023	LSC		12/31/2023	LSC		12/31/2023
ID Prefix	F0814	Correction	ID Prefix	F0880	Correction	ID Prefix		Correction
Reg. #	483.60(i)(4)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #		Completed
LSC		12/31/2023	LSC		12/31/2023	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/22/2023	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315001 Y1	A. Building B. Wing Y2	1/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	100 PLAINSBORO ROAD PLAINSBORO, NJ 08536

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0658	Correction	ID Prefix F0725	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(a)(1)(2)	Completed
LSC	12/15/2023	LSC	12/31/2023	LSC	12/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/22/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
11103L Y1	A. Building B. Wing Y2	1/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	100 PLAINSBORO ROAD PLAINSBORO, NJ 08536

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/31/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ 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
	315001	A. BUILDING **02 - MERWICK CARE & REHAB** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	**100 PLAINSBORO ROAD PLAINSBORO, NJ 08536**

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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 11/16/2023 and 11/17/2023 and Merwick Care and Rehabilitation Center was found to be in noncompliance 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. Merwick Care and Rehabilitation Center is a Two story (2), Type II (000) building that was built in November 2010. The facility is divided into 8 smoke zones. The facility is sprinklered on domestic water. There is supervised smoke detection located in the corridors and in resident rooms. There was one generator outside the facility stated to be tied to the fire alarm control panel, cross corridor doors hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life.	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 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	K 324		11/30/23

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

Electronically Signed | 12/10/2023

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
	315001	A. BUILDING **02 - MERWICK CARE & REHAB** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	**100 PLAINSBORO ROAD PLAINSBORO, NJ 08536**

(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 1 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 interview and review of facility documentation on 11/16/2023 and 11/17/2023, in the presence of facility management, it was determined that the facility failed to inspect the kitchen range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. This deficient practice was identified for 1 of 1 kitchen suppression system and was evidenced by the following: On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the Administrator and Maintenance Staff (MS) to provide all mandatory inspections from 01/01/22 to 11/15/2023 for review. Starting at approximately 9:08 AM, in the presence of the MS a tour of the facility was	K 324	I. - Facility hired a new Maintenance Director to ensure that all required inspections are completed based on the State and Federal deadline requirements. II. - All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director will schedule semi-annual suppression system inspection to ensure that it is completed every six months. - Administrator/Designee will in-service Maintenance Director on adhering to the required time frame on completion of the semi-annual kitchen range-hood fire suppression system inspection.	

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K 324	Continued From page 2 conducted. At approximately 12:02 PM, an inspection inside the kitchen was performed. The surveyor observed on the inspection tag attached to the manual pull station for the kitchen stove's "Wet Chemical" fire suppression system was last semi-annually August 2023. Later at approximately 12:40 PM a review of the facility provided mandatory inspections for the previous 22 months identified was performed. The surveyor reviewed the following Kitchen suppression system inspections, - 12/16/2021 semi-annual suppression system inspection. - 06/14/2022 semi-annual suppression system inspection. - 02/09/2023 semi-annual suppression system inspection. - 08/08/2023 semi-annual suppression system inspection. This review identified the facility conducted one semi-annual inspection for 2022. At approximately 1:59 PM on 11/16/2023, a request was made to the Administrator and MS if the facility could provide any additional kitchen hood semi-annual inspections and to provide them to the surveyor on 11/17/2023. On 11/17/2023 at approximately 8:38 AM, the facility's Administrator informed the surveyor that the facility did not have any additional semi-annual inspections for the kitchen suppression system. The facility did not semi-annually inspect the	K 324	IV. -Maintenance Director/Designee will complete random audits of inspection binder to make sure that the semi-annual kitchen range-hood fire suppression system inspection completed every six months; audits will be conducted monthly X 6 months - 6 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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K 324	Continued From page 3 kitchen suppression system for the 8 months between June 14, 2022 and February 9, 2023. The Administrator and MS confirmed the finding at the times of review. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 11/16/2023 and 11/17/2023, in the presence of the facility management, it was determined that the facility failed to 1) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, and 2) Conduct semi-annual testing of the fire alarm and detection system, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire	K 345	I. - Facility hired a new Maintenance Director to ensure that all required inspections are completed based on the State and Federal deadline requirements. - Semi-annual Fire Alarm and Detection system inspection is scheduled on January 10, 2024. - Smoke detector sensitivity test is scheduled on 12/14/23. II.	1/10/24

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K 345	Continued From page 4 alarm systems and was evidenced by the following: On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the Administrator and Maintenance Staff (MS) to provide all mandatory inspections from 01/01/22 to 11/15/2023 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later at approximately 12:40 PM a review of the facility provided mandatory inspections for the previous 22 months identified was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections, - 12/29/2021 semi-annual inspection. - 05/26/2022 semi-annual inspection. - 02/08/2023 semi-annual inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. The facility conducted one semi-annual inspection for 2022. At approximately 1;55 PM on 11/16/2023, the surveyor asked the facility Administrator and MS they may have to call the fire alarm and detection vendor and ask for a copy of the last smoke detector sensitivity testing. any other semi-annual inspections for 2022 and to provide the copy of the smoke detector sensitivity testing and semi-annual inspection to the surveyor on 11/17/2023 (day two of survey) for review. On 11/17/2023 at approximately 8:38 AM, the Administrator could not provided any additional semi-annual inspection or smoke detector	K 345	- All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director will schedule semi-annual Fire Alarm and Detection system inspection to ensure facility compliance every six months. - Maintenance Director will schedule smoke detector sensitivity test every two years. - Administrator/Designee will in-service Maintenance Director on adhering to the required time frame on completion of semi-annual Fire Alarm and Detection system and smoke detector sensitivity inspections. IV. -Maintenance Director/Designee will complete random audits of inspection binder to make sure that semi-annual Fire Alarm and Detection system inspection completed every six months and smoke detector sensitivity inspection is completed every two years; audits will be conducted monthly X 6 months - 6 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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K 345	Continued From page 5 sensitivity testing. The smoke detector sensitivity testing of the fire alarm and detection system had not been done and the facility conducted one semi-annual inspection of the fire alarm and detection system for the year 2022. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=D	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) This REQUIREMENT is not met as evidenced by:	K 351		12/31/23

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K 351	Continued From page 6 Based on observation, interview and review of facility provided documentation on 11/16/2023, in the presence of facility management it was determined that the facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. This deficient was evidenced by the following, On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the Administrator and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two (2) story building with a basement and has a two story Long Term Care building and a two story Sub-Acute building that are connected. Starting at approximately 9:08 AM on 11/16/2023 and continued on 11/17/2023 in the presence of the facility's MS a tour of the facility was conducted. Along the tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage: On 11/16/2023: 1) At approximately 11:42 AM, the surveyor observed inside Stairwell "B" lower landing no evidence of fire sprinkler coverage for the 4 feet by 8 feet section of landing.	K 351	I. - Regional Maintenance Director called the vendor to schedule the installation of the fire sprinkler inside Stairwell "B" on 11/22/23. - The vendor was scheduled to come to the facility to quote the installation on 12/12/23. II. - All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director/Designee will call the vendor to schedule a sprinkler head installation to cover Stairwell "B" lower landing. - The vendor will be on site to quote and schedule the installation on 12/12/23. - The sprinkler head will be installed on 12/28/2023. IV. - Maintenance Director/Designee will be completing weekly follow up regarding installation and record all communications/follow ups into the maintenance audit form. - Maintenance Director will be communicating progress on installation to the Administrator weekly. - Once the sprinkler head installed, Maintenance Director will continue routine check on all facility sprinkler heads as a part of the daily/weekly/monthly inspections; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next	

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K 351	Continued From page 7 At that time, the surveyor asked the MS, "Do you see a fire sprinkler for the lower landing area?" The MS looked around and stated,"No." The MS confirmed the finding at the time of observation. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	three months - 3 audits, and as needed. - Results of the inspections will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	
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:	K 353		12/31/23

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K 353	Continued From page 8 Based on observation, interview and record review on 11/16/2023 and 11/17/2023 in the presence of facility management, it was determined that the facility failed to comply with the quarterly fire sprinkler system inspections and testing requirements as per NFPA 25 as evidenced by the following: On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the Administrator and Maintenance Staff (MS) to provide all mandatory inspections from 01/01/22 to 11/15/2023 for review. Starting at approximately 9:08 AM, in the presence of the MS a tour of the facility was conducted. At approximately 9:41 PM, an inspection in the basement level where the fire sprinkler control valves were located was performed. The surveyor observed on the two (2) inspection tags attached to the sprinkler control valves had documented the following quarterly (every 3 months) inspection dates: - 12/16/2021, 3/28/2022, 6/14/2022 and 9/16/2022. - 2/07/2023, 5/17/2023 and 8/14/2023. Later, at approximately 12:40 PM a review of the facility provided mandatory quarterly (every 3 months) fire sprinkler system system inspections for the previous 22 months identified was performed. The surveyor reviewed the following Quarterly (every 3 months) fire sprinkler system inspections: - 12/16/2021, 03/28/2022, 06/14/2022 and	K 353	I. - Facility hired a new Maintenance Director to ensure that all required inspections are completed based on the State and Federal deadline requirements. II. - All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director will schedule quarterly fire sprinkler system inspections to ensure that it is completed every three months; next inspection was scheduled on 12/19/23. - Administrator/Designee will in-service Maintenance Director on adhering to the required time frame on completion of the quarterly fire sprinkler system inspections. IV. -Maintenance Director/Designee will complete random audits of inspection binder to make sure that quarterly fire sprinkler system inspections completed every three months; audits will be conducted monthly X 6 months - audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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K 353	Continued From page 9 09/16/2022 quarterly sprinkler inspection. - 02/07/2023, 05/17/2023 and 08/14/2023 quarterly sprinkler inspection. At approximately 1:59 PM on 11/16/2023, a request was made to the Administrator and MS if the facility could provide any additional quarterly (every 3 months)sprinkler system inspections and to provide them to the surveyor on 11/17/2023 (day two of survey). On 11/17/2023 at approximately 8:38 AM, the facility's Administrator informed the surveyor that the facility did not have any additional quarterly (every 3 months)sprinkler system inspections. The facility did not conduct a quarterly fire sprinkler system inspection between 09/16/2022 and 02/07/2023. The facility went five (5) months between quarterly sprinkler system inspections. The facility failed to conducted four (4) quarterly sprinkler inspection for the year 2022 as required per NFPA 25. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 355 SS=F	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.	K 355		11/30/23

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K 355	Continued From page 10 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 11/16/2023 and 11/17/2023 in the presence of facility management, it was determined that the facility failed to:1) perform an annual inspection for 24 of 33 portable fire extinguishers, and 2) replace 1 of 33 portable fire extinguishers when discharged, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. This deficient practice was evidenced by the following: Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1	K 355	I. - On 11/17/23, the facility vendor reported to the facility to complete annual inspection of all 33 facility fire extinguishers. - One (1) ABC Type fire extinguisher to the right of Resident room #230 was replaced with the new one immediately. II. - All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director will be completing annual inspection of all facility fire extinguishers to ensure that facility is in compliance as required by National Fire Protection Association and by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70.. - Administrator/Designee will in-service Maintenance Director on adhering to the required time frame on completion of annual inspection of all facility fire extinguishers IV. -Maintenance Director/Designee will complete random audits on fire extinguishers inspections; audits will be completed monthly for 6 months - 6 audits, and as needed. - Results of the audits will be presented to	

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K 355	Continued From page 11 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the facility Administrator and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with two buildings (Long Term Care and Sub-Acute) that are connected and a basement. Starting at approximately 9:08 AM on 11/16/2023 and continued on 11/17/2023 in the presence of the facility's MS a tour of the facility was conducted. During the two (2) day building tour the surveyor observed and inspected thirty-three (33) portable fire extinguishers in various locations with the following issues that were identified: On 11/16/2023: 1) During an inspection on the basement level the surveyor observed eleven (11) ABC-Type fire extinguishers and one (1) Class K-Type wet chemical fire extinguisher in various locations that were last annually inspected September 2022. 2) While on tour on the second floor of the Long Term Care building the surveyor observed eight (8) fire extinguishers in various locations that were last annually inspected September 2022. At approximately 10:39 AM, the surveyor	K 355	the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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K 355	Continued From page 12 observed one (1) ABC Type fire extinguisher to the right of Resident room #230 with the pressure indicating needle in the "RED" discharge zone on the gauge. This fire extinguisher would not function properly in the event of a fire. At that time. a request was made to the MS to replace the fire extinguisher. The MS complied with the request. 3) During an inspection on the first floor Long Term Care building the surveyor observed six (6) ABC-Type fire extinguishers and one (1) Class K-Type wet chemical fire extinguisher in various locations that were last annually inspected September 2022. The facility's MS confirmed the findings at the time of observations. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced	K 521		12/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02 - MERWICK CARE & REHAB** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	**100 PLAINSBORO ROAD PLAINSBORO, NJ 08536**

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K 521	Continued From page 13 by: Based on observations on 11/16/2022 and 11/17/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 2 of 8 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the facility Administrator and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many resident sleeping rooms are in the facility. The MS didn't know how many resident sleeping rooms were in the facility. A review of the facility provided lay-out identified the facility is a two-story building with a basement. Starting at approximately 9:08 AM on 11/16/2023 and continued on 11/17/2023 in the presence of the facility's MS a tour of the facility was conducted. During the two (2) day building tour the surveyor inspected inside eight (8) Resident sleeping room bathrooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 2 of 8 resident bathrooms in the following locations:	K 521	I. - On 12/4/2023, Maintenance Director replaced 2 roof top motors to fix ventilation system in the rooms #151 and #135 II. - All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director will inspect all roof top motors that responsible for the ventilation of the building to ensure that facility is in compliance with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2. - Administrator/Designee will in-service Maintenance Director on proper maintenance of the facility ventilation systems. IV. -Maintenance Director/Designee will complete random audits of the resident rooms and bathrooms to ensure that ventilation system works properly; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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K 521	Continued From page 14 On 11/17/2023: 1. At approximately 10:31 AM, inside the first (1st.) floor Residents room #151 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:43 AM, inside Resident room #135 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The MS confirmed the findings at the time of observations. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 918 SS=E	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	K 918		12/31/23

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	315001	A. BUILDING **02 - MERWICK CARE & REHAB** B. WING _____	**11/22/2023**

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K 918	Continued From page 15 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 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 and interview on 11/16/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced by the following: On 11/16/2023 (day one of survey) during the	K 918	I. - Regional Maintenance Director called vendor to schedule the installation of the remote manual stop for the generator located outside on 11/16/23. - On 12/7/23, vendor was on the site to provide estimate of the remote manual stop for the generator. II. - - All residents have the potential to be affected by the same deficient practice.	

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	315001	A. BUILDING **02 - MERWICK CARE & REHAB** B. WING _____	**11/22/2023**

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K 918	Continued From page 16 survey entrance at approximately 8:37 AM, a request was made to the facility Administrator and Maintenance Staff (MS) if the facility had an Emergency Generator. The MS told the surveyor that the facility had one (1) 300 KW Diesel Emergency Generator." Starting at approximately 9:08 AM in the presence of the facility's MS a tour of the facility was conducted. Along the building at approximately 9:51 AM, an inspection outside of the building where the emergency generator was located was performed. The surveyor observed that the emergency stop button was located on the metal housing of the generator. At that time, the surveyor asked the MS, "Do you have a remote emergency stop button for the generator?" The MS said, "no." The MS confirmed the finding at the time of inspection. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	III. - On 12/13/23, vendor will complete the installation of the remote manual stop for the generator. - Administrator/Designee will in-service Maintenance Director on requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. IV. - Regional Maintenance and Facility Maintenance Directors will monitor installation of the remote manual stop for the generator. - Maintenance Director will ensure the completion of the installation of the remote manual stop. - Maintenance Director will communicate progress of the installation to the Administrator. - Maintenance Director/Designee will complete weekly audits to ensure delivery/installation/proper functioning of the remote switch; audits will be conducted weekly X 4 weeks - 4 audits, then monthly X 3 months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for three (4) months for review and revision as deemed appropriate.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		11/30/23

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	315001	A. BUILDING **02 - MERWICK CARE & REHAB** B. WING _____	**11/22/2023**

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K 923	Continued From page 17 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 11/16/2023 in the presence of facility management it was determined that the facility failed to provide a	K 923	I. - On 11/17/23, the facility vendor reported to the facility to remove three (3) rolling carts with seventy-one (71) "E" size full	

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K 923	Continued From page 18 secured storage location for 300 cubic feet to 3,000 cubic feet of oxygen with a Non combustible enclosure capable of being secured in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3 and 11.3.4. This deficient practice was evidenced by the following: Reference: National Fire protection Association (NFPA) Standards 99 Health Care Facilities, Definitions, - One "E-size cylinder" = 24.96 cu ft. - Twelve "E-size cylinder" = 299.52 cu ft. - H Cylinder = approximately 250 cu ft. NFPA 99 2012 edition 11.3.2.1 through 11.3.2.3 Storage of Oxygen 300 cubic feet to 3000 cubic feet, Construction assembly, Non-combustible enclosure capable of being secured. On 11/16/2023 (day one of survey) during the survey entrance at approximately 8:37 AM, a request was made to the facility Administrator and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story building with a basement. Starting at approximately 9:08 AM in the presence of the facility's MS a tour of the facility was conducted. Along the building at approximately 9:27 AM, an	K 923	oxygen tanks from the exit access basement corridor. II. - All residents have the potential to be affected by the same deficient practice. III. - Maintenance Director will be completing daily rounds of the basement area to ensure that the facility provides a secured storage location for 300 cubic feet to 3,000 cubic feet of oxygen with a Non combustible enclosure capable of being secured in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3 and 11.3.4.. - Administrator/Designee will in-service Maintenance Director on proper storage of the oxygen E-Tanks in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3 and 11.3.4. IV. -Maintenance Director/Designee will complete random audits on storage of the oxygen E-Tanks; audits will be conducted weekly X 4 weeks - 4 audits, bi-weekly X 4 weeks - 2 audits, then monthly for next three months - 3 audits, and as needed. - Results of the audits will be presented to the monthly QAPI meeting for six (6) months for review and revision as deemed appropriate.	

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K 923	Continued From page 19 inspection in the basement level was performed. The surveyor observed in the exit access corridor three (3) rolling carts with seventy-one (71) "E" size oxygen tanks. At that time, the surveyor asked the MS, "Are these oxygen tanks full?" The MS looked at the oxygen tanks and told the surveyor, "yes they are." Further inspection of the pressure gauges identified these 71 E-Tanks (1,772.16 cubic feet) were full. A review of an emergency evacuation diagram posted in the area on a wall identified the access corridor is the primary and / or secondary exit access to reach an exit. The MS confirmed the finding at the time of observation. The facility did not provide a Non-combustible enclosure capable of being secured the 71 E-size full oxygen tanks. The Administrator was informed of the findings during the survey exit on 11/17/2023 at approximately 12:10 PM. Fire Safety Hazard. NJAC - 31.2 (e) NFPA 99	K 923		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315001 Y1	A. Building 02 - MERWICK CARE & REHAB B. Wing Y2	1/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERWICK CARE & REHABILITATION CENTER	100 PLAINSBORO ROAD PLAINSBORO, NJ 08536

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	11/30/2023	LSC K0345	01/10/2024	LSC K0351	12/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	12/31/2023	LSC K0355	11/30/2023	LSC K0521	12/31/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	12/31/2023	LSC K0923	11/30/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO