STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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** 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING **02** 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 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