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 _____	**02/07/2022**

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
E 000	Initial Comments An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on February 7th, 2022 following New Jersey Department of Health, Health Facility Survey and Field Operations survey on December 14th 2021. At this Comparative Federal Monitoring Survey, Merwick Care and Rehabilitation was found not to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness, is NOT MET.	E 000		
E 026 SS=F	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) §403.748(b)(8), §416.54(b)(6), §418.113(b)(6)(C)(iv), §441.184(b)(8), §460.84(b)(9), §482.15(b)(8), §483.73(b)(8), §483.475(b)(8), §485.542(b)(7), §485.625(b)(8), §485.920(b)(7), §494.62(b)(7). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate	E 026		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 026	Continued From page 1 care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to develop, implement and conduct annual updates of emergency preparedness policies and procedures to address the role of the facility under a 1135 Waiver. Findings Include: Document review and interview on February 2, 2022 approximately 3:20 PM revealed facility's "Emergency Preparedness Plan" did not include policies and procedures and role of the facility under a 1135 Waiver. The finding was verified by the Administrator, Maintenance Director and Regional Plant Manager at the time of the observation.	E 026		
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on February 7th, 2022 following New Jersey Department of Health, Health Facility Survey and Field Operations survey on December 14th,	K 000		

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K 000	Continued From page 2 2021. At this Comparative Federal Monitoring Survey, Merwick Care and Rehabilitation was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The facility was originally constructed in 2010 as two-story building Type II (000). 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. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: quarterly fire drills, fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 200 certified beds. At the time of the survey the census was 156. The requirement at 42 CFR Subpart 483.90(a) is	K 000		

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K 000	Continued From page 3 NOT MET as evidenced by:	K 000		
K 111 SS=E	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced	K 111		

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K 111	Continued From page 4 by: Based on observation and interview, the facility failed to conduct daily inspection of construction repair, alterations or additions and fire barrier having a 1-hour fire resistance rating are in place and continuously maintained in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.1.4.3 and 4.6.7 and 1135 waiver. The deficient practice could affect 30 of 156 residents at the time of the survey. Findings include: Observation on February 7, 2022 at approximately 11:52 AM bathroom (room #202) revealed approximately nine-foot by six-foot ceiling was removed, approximately three-inch by two-inch penetration in corridor wall was not fire stopped and there was no fire barrier between repair and renovation areas and occupied space. Interview on February 7, 2022 at approximately 3:00 PM with Maintenance Director revealed daily inspection of construction repair, alterations or additions and fire barriers was not recorded. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the time of the observation.	K 111		
K 132 SS=F	Multiple Occupancies - Contiguous Non-Health CFR(s): NFPA 101 Multiple Occupancies - Contiguous Non-Health Care Occupancies Non-health care occupancies that are located immediately next to a Health Care Occupancy,	K 132		

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K 132	Continued From page 5 but are primarily intended to provide outpatient services are permitted to be classified as Business or Ambulatory Health Care Occupancies, provided the facilities are separated by construction having not less than 2-hour fire resistance-rated construction, and are not intended to provide services simultaneously for four or more inpatients. Outpatient surgical departments must be classified as Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.4.1, 19.1.3.4.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, dialysis unit was surveyed at the same time as the nursing facility, because the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.3.4. The deficient practice could affect all residents. Findings Include: Observation on February 7, 2022 at approximately 12:54 PM dialysis unit and nursing fire wall above the ceiling revealed four-inch diameter hole, two penetrations by plumping pipe and four conduits not fire stopped. Observation on February 7, 2022 at approximately 12:58 PM dialysis unit and nursing facility fire door revealed one quarter inch gap vertically along the edge of the door and frame preventing it from being fire resistive. Observation on February 7, 2022 at approximately 12:59 PM dialysis unit and nursing fire door had no visible label with fire resistive	K 132		

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K 132	Continued From page 6 properties required for an opening in a two-hour rated horizontal separation assembly. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the time of the observation.	K 132		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location	K 222		

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K 222	Continued From page 7 within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. The deficient practice could affect	K 222		

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K 222	Continued From page 8 60 of 156 residents at the time of the survey. Findings include: Observation on February 7, 2022 at approximately 10:43 AM rehabilitation exit door (internal) revealed thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. Observation on February 7, 2022 at approximately 10:44 AM rehabilitation exit door (external) revealed thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. Observation on February 7, 2022 at approximately 11:30 AM second floor door to open stairwell (adjacent to family room) revealed releasing of the delayed egress magnetic locking device by pushing the door was not a single action and required the door handle to be turned to activate the delayed egress magnetic locking device that could impede or prevent emergency use of such means of egress. Observation on February 7, 2022 at approximately 11:36 AM long term care exit door (internal) revealed thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. Observation on February 7, 2022 at approximately 11:37 AM long term care exit door (external) revealed thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the	K 222		

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K 222	Continued From page 9 exit. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the time of the observation	K 222		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide unobstructed exit discharges in accordance with NFPA 101, 2012 Edition, Section 19.2.7 and 7.7. The deficient practice could affect 50 of 156 residents at the time of the survey. Findings include: Observation on February 7, 2022 at approximately 10:54 AM Rehabilitation courtyard exit gate revealed key code on the egress side. There was no signage indicating the procedure to open the gate potentially confusing or prohibiting visitors and residents from using the facility designated exit that could restrict emergency use of the exit. Observation and Interview on February 7, 2022 at	K 271		

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K 271	Continued From page 10 approximately 10:55 AM Rehabilitation Staff A was asked "What is the key code to open the locked gate from the courtyard" Staff A responded 'I do not know the key code". All staff did not have key code to locked gates and procedure for locked gates was not included in fire safety training plan. The findings were verified by Administrator, Maintenance Director and Staff A at the time of the observation.	K 271		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice could affect approximately 30 of 156 residents. Findings Include: Observation on February 7, 2022 at approximately 10:46 AM rehabilitation entrance lobby revealed switch controlling normal lighting	K 281		

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K 281	Continued From page 11 supplied normal and emergency lighting for the means of egress and had no lighting when the switch was in the off position. Observation on February 7, 2022 at approximately 10:47 AM rehabilitation corridor revealed switch controlling normal lighting supplied normal and emergency lighting for the means of egress and had no lighting when the switch was in the off position. The findings were verified by Administrator and Maintenance Director at the times of the observation.	K 281		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		

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K 321	Continued From page 12 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to provide a fire barrier with one hour fire resistance rating in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1 and 8.7.1. The deficient practice could affect all residents. Findings Include: Observation on February 7, 2022 at approximately 1:05 PM laundry room (basement) revealed steel beams and composite metal deck was not enclosed in fire-rated material. Observation on February 7, 2022 at approximately 1:08 PM housekeeping storage room (basement) revealed steel beams and composite metal deck was not enclosed in fire-rated material. Observation on February 7, 2022 at approximately 1:13 PM maintenance shop (basement) revealed steel beams and composite metal deck was not enclosed in fire-rated material. Observation on February 7, 2022 at	K 321		

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K 321	Continued From page 13 approximately 1:19 PM boiler room (basement) revealed steel beams and composite metal deck was not enclosed in fire-rated material. Observation on February 7, 2022 at approximately 1:22 PM storage area in corridor (basement) exceeded 50 square feet, contained combustible boxes and equipment, and was only separated from the corridor by metal wire fence from floor to ceiling. Observation on February 7, 2022 at approximately 1:30 PM elevator machine room (basement) revealed steel beams and composite metal deck was not enclosed in fire-rated material. Record review and interview on February 7, 2022 at approximately 3:15 PM during the exit conference with the Administrator, Maintenance Director and Regional Plant Manager building plans revealed "Exterior Wall Sections A3.55 Section Typical" "One (1) Hour Fire Resistive Rated Floor Assembly - UL G551". Maintenance Director confirmed sheetrock was applied to all floors above lay-in tiles except basement ceilings. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the times of the observation.	K 321		
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,	K 353		

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	315001	A. BUILDING **02** B. WING _____	**02/07/2022**

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K 353	Continued From page 14 Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the sprinkler system, ensuring the ceiling level was smoke resisting in accordance with NFPA 101, 2012 Edition, Section 19.3.5, 19.3.5.1, 9.7.5, 9.7.7, 9.7.8, NFPA 25, 2011 Edition, Section 5.1 and 5.2.1.1. The deficient practice could affect approximately 60 of 156 residents. Findings Include: Observation on February 7, 2022 at approximately 11:10 AM sub-acute first floor electrical room revealed ceiling penetrations by communication wiring and conduit was sealed with brown foam sealant, administrator was interviewed and stated that sealant was original to the building and it was not known if it was a firestop, Through Penetration System (TPS) installed.	K 353		

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K 353	Continued From page 15 Observation on February 7, 2022 at approximately 11:12 AM sub-acute first floor corridor (adjacent to room 160) revealed four-foot by two-foot section of ceiling tile was not set in place allowing hot gasses and smoke past the sprinkler into the space above. Observation on February 7, 2022 at approximately 11:16 AM sub-acute first floor medication room revealed four-foot by two-foot section of ceiling tile was not set in place allowing hot gasses and smoke past the sprinkler into the space above. Observation on February 7, 2022 at approximately 12:01 PM Computer room storage revealed ceiling penetrations by plumping pipe not properly fire stopped allowing hot gasses and smoke past the sprinkler into the space above. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the times of the observation.	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to visually inspect fire extinguishers monthly and retain record of last	K 355		

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K 355	Continued From page 16 twelve monthly inspections performed in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10, 2010 Edition. The deficient practice could affect approximately 30 of 156 residents. Findings include: Observation on February 7, 2022 at approximately 10:56 AM rehabilitation corridor revealed corrosion along the bottom and sides of the fire extinguisher, the annual inspection label was October 2021 and inspection tag recorded monthly inspections on 10/01/21, 11/01/21, 12/02/21, 01/01/22 and 02/01/22. Observation, document review and interview on February 7, 2022 at approximately 3:10 PM during the exit conference with the Administrator, Maintenance Director and Regional Plant Manager revealed there was no record of the last twelve monthly inspections for fire extinguishers in the facility. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the times of the observation.	K 355		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective	K 374		

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K 374	Continued From page 17 plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide doors in smoke barrier walls that did not have gaps between the doors to resist fire for a minimum of twenty-minutes in accordance with NFPA 101, 2012 Edition, Section 19.3.7.6, 19.3.7.8 and 19.3.7.9. The deficient practice could affect approximately 60 of 156 residents. Findings Include: Observation on February 7, 2022 at approximately 11:02 AM smoke doors (1st floor sub-acute) revealed one-quarter inch gap between the meeting edges preventing it from being smoke resistive. Observation on February 7, 2022 at approximately 11:26 AM smoke doors (2nd floor sub-acute) when released from magnetic hold-open door device one door did not close, there was a one-half inch opening between doors preventing it from being smoke resistive. The findings were verified by Administrator, Maintenance Director and Regional Plant	K 374		

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K 374	Continued From page 18 Manager at the times of the observation.	K 374		
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that elevators are inspected and tested monthly in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. The deficient practice could affect all residents. Findings include: Observation, interview and record review, on February 7, 2022 at approximately 3:20 PM there	K 531		

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K 531	Continued From page 19 was no evidence that Fire Fighters' Emergency Operations Inspection and Test was performed and written record of Phase I recall by use of the key switch, and a minimum of one?floor operation, including findings documented monthly. Record review of document "Generator Maintenance" dated 02/8/21 only recorded "PASS elevator # 1, # 2, # 3 # 4 # 5" "left elevator running" YES" with a correction mark. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the times of the observation	K 531		
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 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	K 923		

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K 923	Continued From page 20 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 interview the failed to provide wall-ceiling assembly with one-hour fire resistance rating in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3 and 11.3.4. The deficient practice could affect all residents. Findings Include: Observation on February 7, 2022 at approximately 1:24 PM oxygen storage room (basement) revealed approximately eighty full E-sized oxygen cylinders, eight full H- sized oxygen cylinders and bulk oxygen system. The ceiling steel beams and composite metal deck was not enclosed in fire-rated material. Record review and interview on February 7, 2022 at approximately 3:15 PM during the exit conference with the Administrator, Maintenance Director and Regional Plant Manager building	K 923		

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K 923	Continued From page 21 plans revealed "Exterior Wall Sections A3.55 Section Typical" "One (1) Hour Fire Resistive Rated Floor Assembly - UL G551". Maintenance Director confirmed sheetrock was applied to all floors above lay-in tiles except basement ceilings. The findings were verified by Administrator, Maintenance Director and Regional Plant Manager at the times of the observation.	K 923		