| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **MERWICK CARE & REHAB CENTER, LLC** | **100 PLAINSBORO ROAD PLAINSBORO, NJ 08536** |

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| F 000 | INITIAL COMMENTS<br><br>Complaint #: NJ 184813, 184567, 174484, 184592<br><br>Survey Date: 4/2120/25-4/25/2025<br><br>Census: 162<br><br>Sample: 32 + 3 closed records.<br><br>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all | F 550 | | 5/23/25 |

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

Electronically Signed | 05/16/2025

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 550 | Continued From page 1<br>residents regardless of payment source.<br><br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to treat each resident with respect and dignity in a manner that promotes his/her quality of life. This deficient practice was identified for 1 of 32 residents (Resident #123) reviewed for resident rights.<br><br>Upon initial tour of the facility on 04/21/2025 at 11:15 AM, the surveyor was speaking with Resident #123 in their room with the door closed. While speaking with the resident, the door opened and Registered Nurse #1 (RN#1) attempted to enter. Resident #132 shook their head, looked at the surveyor, and stated [redacted]. This surveyor stated that they were speaking with the resident and RN #1 exited the room. Approximately 5 minutes later, RN #1 knocked, immediately entered the room, walked | F 550 | I.<br>- RN #1 was provided with 1-1 Employee Education on Resident Rights, which consist of knocking when entering resident rooms, including Resident #123 and Resident #132's room, and providing privacy as requested for all residents, including Resident #123 and Resident #132.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Director Of Nursing/Designee in-serviced facility staff on Resident Rights for privacy, including knocking on the door prior to entering the room, waiting for | |

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| F 550 | Continued From page 2<br>past the surveyor and began to set up [NJ Exec Order 26] care supplies. This surveyor explained that they were with the Department of Health and would like to speak with the resident. RN #1 stated that they had to set up for [NJ Exec Order 26] care. The surveyor requested RN #1 three different times to exit the room to allow privacy.<br><br>During an interview with the surveyor on 04/21/2025 at 11:31 AM, the [US FOIA (b)(6)] confirmed that RN #1 acknowledged she should have knocked, announced their presence, and stated their purpose when they entered the room. When asked what should have been done when the surveyor requested privacy, [US FOIA (b)(6)] stated that RN #1 should have provided privacy and exited the room when requested.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Exec Orde]<br><br>A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b1], the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Exe] out of 15, which indicated the resident's [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b1]<br><br>During an interview with the surveyor on 04/25/2025 at 09:40 AM, the [US FOIA (b)(6)], in the presence of the [US FOIA (b)(6)] acknowledged that residents have an expectation of privacy. | F 550 | permission to enter, introducing yourself and explaining the purpose of the visit, and seeking residents permission to perform the procedure.<br><br>IV.<br>-Director Of Nursing/Designee will perform random observations of interactions with staff members and residents to ensure residents privacy is honored; random observations will be conducted weekly x 4 weeks then monthly for (3) three months 5 staff members will be observed.<br>- Results of the random observations will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 550 | Continued From page 3<br><br>A review of the facility's undated "Resident Rights" policy included the following under Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity... | F 550 | | |
| F 584 SS=D | NJAC 8:39-4.1 (a) 12<br>Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition; | F 584 | | 5/23/25 |

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| F 584 | Continued From page 4<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, it was determined the facility failed to maintain the resident's living environment in a clean, sanitary, and homelike manner that included a wall-mounted call device input (Resident #13) and soap dispensers (Resident #17 and #49). This deficient practice was identified for 2 of 4 nursing units observed for environment.<br><br>This deficient practice was evidence by the following:<br><br>1. During the initial tour of the facility on 4/21/25 at 10:16 AM, the Surveyor #1 observed a call device input system taped to the wall above the resident's bed in room #[redacted] bed #[redacted]<br><br>On 4/22/25 at 9:15 AM, the surveyor interviewed Resident #13's family member that stated that the call device input box had been taped to the wall for at least a month and that the Maintenance Department was aware of it and waiting on a new system to replace it. The family member | F 584 | I.<br>-The wall call device input system in room #[redacted] bed #[redacted] was repaired immediately; the call bell device continues to function.<br>- Brown-colored debris on both the wall and floor in Resident # 133s bedroom was cleaned immediately.<br>-The wall-mounted soap dispensers drip trays in Resident # 49s was attached back to the base immediately.<br>-The wall-mounted soap dispensers drip trays in Resident # 17s was attached back to the base immediately.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Environmental Services Director/Maintenance Director/Designee educated housekeeping and maintenance staff on facility policy and procedures on | |

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| F 584 | Continued From page 5<br>confirmed that the call device had been functioning properly.<br><br>During an interview with the surveyor on 4/24/25 at 12:34 PM, the US FOIA (b)(6) [redacted]) stated that they are aware of the taped call device input box that was inherited from the previous management and that they are working on replacing the entire call device system. At that time, the surveyor expressed concern regarding the safety of the unsecured box.<br><br>On 4/25/25 at 10:05 AM during a meeting with the facility administration, the US FOIA (b)(6) stated that the call device input box had been secured to the wall by the Maintenance Department.<br><br>A review of the undated facility provided policy titled, "Homelike Environment", revealed, "Residents are provided with a safe, clean, comfortable, and homelike environment."<br><br>N.J.A.C. 8:39-31.4(a)<br><br>2. On 04/21/2025 at 10:17 AM, Surveyor #2 observed brown-colored debris on both the wall and floor in Resident #133's bedroom.<br><br>On 04/21/2025 at 10:58 AM, Surveyor #2 observed that the wall-mounted soap dispenser's drip tray was detached from the wall in Resident #49's bathroom, located on the NJ Exec Order 26 floor of the NJ Exec Order 26.4b1 Unit.<br><br>On 04/22/2025 at 11:40 AM, Surveyor #2 observed that the wall-mounted soap dispenser's drip tray was detached from the wall in Resident #49's bathroom. | F 584 | Homelike Environment to ensure all residents are provided with a safe, clean, comfortable, and homelike environment.<br><br>IV.<br>-Department Heads/Designees will conduct daily room audits through Ambassador Programs daily rounds, including observations of the call device input system being appropriately installed, all room walls are clean and debris free, and wall-mounted soap dispensers are properly working. Daily room Ambassador round reports will be recorded through Ambassador Rounds electronic system weekly x 4 weeks then monthly for next three (3) months.<br>- Results of the random observations will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 584 | Continued From page 6<br><br>On 04/22/2025 at 11:51 AM, Surveyor #2 observed that the wall-mounted soap dispenser's drip tray was detached from the wall in Resident #17's bathroom, located on the [NJ Exec Order 26] floor of the [NJ Exec Order 26.4b1] Unit.<br><br>On 04/23/2025 at 9:20 AM, Surveyor #2 observed that the wall-mounted soap dispenser's drip tray was detached from the wall in Resident #49's bathroom.<br><br>On 04/23/2025 at 10:32 AM, Surveyor #2 observed that the wall-mounted soap dispenser's drip tray was detached from the wall in Resident #17's bathroom.<br><br>On 04/24/2025 at 10:49 AM, Surveyor #2 observed that the wall-mounted soap dispenser's drip tray was detached from the wall in Resident #49's bathroom.<br><br>During an interview with Surveyor #2 on 04/24/2025 at 10:31 AM, a facility maintenance staff member (MS) said that each morning, MS conducts daily rounds throughout the facility, including visits to the nursing stations on every unit to review the maintenance log and ask nursing staff if there are any maintenance issues that need attention. MS also said that he was unaware of the detached wall-mounted soap dispenser drip trays in the bathrooms of Residents #17 and #49.<br><br>During an interview with Surveyor #2 on 04/24/2025 at 10:36 AM, Registered Nurse/Unit Manager #1 said that, to ensure a clean and homelike environment, the wall-mounted soap dispensers drip trays should be attached to the | F 584 | | |

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| F 584 | Continued From page 7<br>wall, and there should be no brown debris present on the walls or floors.<br><br>During an interview with Surveyor #2 on 04/15/2025 at 12:24 PM, the US FOIA (b)(6) [redacted] said that the drip tray of the wall-mounted soap dispenser should be securely attached and functional, and no brown debris should be present on the walls or floors to maintain a clean and homelike environment.<br><br>A review of the undated facility provided policy titled, "Homelike Environment", revealed, "Residents are provided with a safe, clean, comfortable, and homelike environment." | F 584 | | |
| F 640 SS=D | N.J.A.C. 8:39-31.4(a)<br>Encoding/Transmitting Resident Assessments<br>CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the | F 640 | | 5/23/25 |

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| F 640 | Continued From page 8<br>CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.<br><br>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:<br>(i)Admission assessment.<br>(ii) Annual assessment.<br>(iii) Significant change in status assessment.<br>(iv) Significant correction of prior full assessment.<br>(v) Significant correction of prior quarterly assessment.<br>(vi) Quarterly review.<br>(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.<br><br>§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that the facility failed to transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 2 of 2 residents reviewed for resident assessment (Resident #9 and Resident # 147). This deficient practice was evidenced by: | F 640 | I.<br>-Two (2) discharge Medical Data Sets for Resident #9 and Resident #147 were immediately unlocked, marked for submission to CMS, transmitted successfully, and accepted into the database. | |

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| F 640 | Continued From page 9<br>The MDS is a comprehensive federal mandated process for clinical assessment of all residents that should be completed and submitted to the Quality Measure System. The facility must electronically transmit the MDS no later than 14 days after assessment being completed. After transmitting of the MDS, it will generate a quality measure to enable a facility to monitor the residents decline and progress.<br><br>The following residents were identified that the MDS were not transmitted timely:<br><br>1. Resident #9: the discharge return anticipated MDS was completed on NJ Exec Order 26.4b1 and was due to be transmitted no later than NJ Exec Order 26.4b1. It was transmitted NJ Exec Order 26.4b1.<br>2. Resident #147: the discharge return not anticipated MDS was completed on NJ Exec Order 26.4b1 and was due to be transmitted no later than NJ Exec Order 26.4b1. It was transmitted on NJ Exec Order 26.4b1.<br><br>04/23/2025 12:18 PM, during an interview with the surveyor, the US FOIA (b)(6) stated that MDS's should be transmitted within 2 weeks of completion. The US FOIA (b)(6) acknowledged that Resident #9 and Resident #147 discharge MDSs were transmitted late.<br><br>The facility provided policy titled, "MDS Completion and Submission Timeframes", with a revision date of July 2017 reflected our facility will conduct and submit resident assessments in accordance with federal and state submission timeframes.<br><br>NJAC 8:39-11.1 | F 640 | II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-All other Medical Data Sets in the completed state back 2-year period were reviewed by RDCM to ensure all Medical Data Sets that needed to be submitted were submitted; no other Medical Data Sets were found that were marked as do not submit and should have been submitted.<br>- Regional Medical Data Set Director educated Medical Data Set staff on facility policy and procedures on Medical Data Set Completion and Submission Timeframes to ensure that all resident assessments will be completed and submitted in accordance with Federal and State submission timeframes.<br><br>IV.<br>-Director of Nursing/Designee will conduct random audits on all residents assessments to ensure that all assessments will be completed and submitted in accordance with Federal and State submission timeframes; random audits will be conducted weekly x 4 weeks 5 assessments will be audited then monthly for next three (3) months 5 assessments will be audited.<br>- Results of the random observations will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 658 | Continued From page 10 | F 658 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and pertinent facility documentation, it was determined that the facility nursing staff failed to document on the Treatment Administration Record (TAR) to indicate that treatments were administered according to the Physician Orders (PO) and acceptable standards of clinical practice in accordance with the New Jersey Board of Nursing Statutes. The deficient practice was identified for 1 of 41 residents (Resident #49).<br><br>This deficient practice was evidenced by the following:<br><br>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 casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."<br><br>Reference: New Jersey Statutes Annotated, Title | F 658 | I.<br>- The [redacted] that provided treatment/care for the Resident # 49 was educated on following facility policy and procedures on completing Treatment Administration Record documentation in electronic medical records system that treatment was completed as ordered.<br><br>II.<br>-All residents have the potential to be affected by the same deficient practice.<br><br>III.<br>-Director of Nursing/Designee completed in-service of all licensed nursing staff on facility policy and procedure on recording all provided treatment administration in electronic medical records system to ensure that treatments were administered according to the Physician Orders (PO).<br><br>IV.<br>-Director of Nursing/Designee will perform random audits of the resident Treatment Administration Records to ensure that treatments were administered and documented according to the Physician Orders (PO); random audits will be | 5/23/25 |

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| F 658 | Continued From page 11<br>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 restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>A review of the Admission Record revealed Resident #49 was admitted to the facility with diagnoses including but not limited to: [redacted].<br><br>A review of Resident # 49 's TAR dated [redacted], revealed the following PO:<br><br>[redacted] every shift for [redacted]. A review of the TAR dated [redacted], did not include documentation that the treatment was completed as ordered on [redacted]<br><br>Apply [redacted] to [redacted] every shift for [redacted]. A review of the TAR dated [redacted] did not include documentation that the treatment was completed as ordered on [redacted].<br><br>[redacted] every shift. A review of the TAR dated [redacted], did not include documentation that the treatment was completed as ordered on | F 658 | conducted weekly x 4 weeks - 5 resident Treatment Administration Records will be audited, then monthly for next three (3) months - 5 resident Treatment Administration Records will be audited . - Results of the random audits will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 658 | | F 658 | | |

Continued From page 12

NJ Exec Order 26.4b1.

NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 while in bed every shift. A review of the TAR dated NJ Exec Order 26.4b1, did not include documentation that the treatment was completed as ordered on NJ Exec Order 26.4b1

NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 e), apply NJ Exec Order 26.4b1 on the NJ Exec O to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b to NJ Exec Order 26 of NJ Exec Order 26.4b1 every shift and as needed for NJ Exec Order 26.4b1. A review of the TAR dated NJ Exec Order 26.4b1 did not include documentation that the treatment was completed as ordered on NJ Exec Order 26.4b1.

NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b NJ Exec Order 26.4, and NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A review of the TAR dated NJ Exec Order 26.4b1, did not include documentation that the treatment was completed as ordered on NJ Exec Order 26.4b1.

On 04/23/2025 at 1:05 PM, Surveyor reviewed NJ Exec Order 26.4b facility US FOIA (b)(6) medication regimen review for Resident #49, which noted blank entries on the Medication Administration Record (MAR). Further review of the resident's MAR and TAR for NJ Exec Order 26.4b revealed undocumented treatments on the TAR for the evening shift o NJ Exec Order 26.4b1, with no explanation in the EMR for the undocumented treatments.

During an interview with Surveyor #2 on 04/24/2025 at 12:24 PM, the US FOIA (b)(6) said that there should be no blank entries on the TAR, because blanks

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| F 658 | Continued From page 13<br>indicate that treatments were not administered.<br><br>The facility was unable to provide a policy outlining procedures for documentation on the TAR.<br><br>NJAC 8:39-11.2 (a) (b), 27.1 (b), 29.2 (a) | F 658 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to A). store [NJ Exec Order 26] equipment in a sanitary manner B.) develop a comprehensive care plan for a resident receiving [NJ Exec Order 26.4b1] and a resident who [NJ Exec Order 26.4b1] C.) label and date [NJ Exec Order 26.4b1] according to professional standards and failed to obtain a physician order for a resident receiving [NJ Exec Order 26.4b1]. This deficient practice was identified in 3 of 4 residents (Resident #70; Resident #152; Resident #472) reviewed for [NJ Exec Order 26.4b1] care and was evidenced by the following:<br><br>A.) On 4/21/25 at 10:08 AM during the initial tour of the facility, surveyor # 1 observed an [NJ Exec Order 26] | F 695 | I.<br>-A [NJ Exec Order 26.4b1] ) to the [NJ Exec Order 26.4b1] that was on the floor under the Resident # 70s bedside table was removed from the floor and discarded; [NJ Exec Order 26.4b1] was provided to the Resident #70.<br>-A focus area for [NJ Exec Order 26.4b1] was included to the Resident #70s individual comprehensive care plan (ICCP) as per physician order (PO).<br>- Unlabeled Resident #152s [NJ Exec Order 26] was discarded; resident was provided with new properly labeled [NJ Exec Order 26.4b1] immediately.<br>- A focus area for [NJ Exec Order 26] use was | 5/23/25 |

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| F 695 | Continued From page 14<br>NJ Exec Order 26.4b1 in Resident # 70's room with a NJ Exec Order 26.4b1 connected to the NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 was found on the floor under the bedside table.<br><br>A review of the Admission Record, an admission summary, revealed that Resident #70 had medical diagnoses which included but were not limited to: NJ Exec Order 26.4b1<br><br>A review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26 identified that the resident had a 'NJ Exec Order 26.4b1 and included the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated the resident's NJ Exec Order 26.4b1 . Further review of the MDS revealed the resident was placed on NJ Exec Order 26.4b NJ Exec Order 26 In addition, under section 'NJ Exe Special Treatments, Procedures, and Programs, it was indicated that the resident was on NJ Exec Order 26.4<br><br>A review of the Physician Order Summary dated as of NJ Exec Order 26.4, revealed that Resident #70 was prescribed NJ Exec Order 26 to be administered at NJ Exec Order 26.4b1 via a NJ Exec Order 26.4b1 as needed for NJ Exec Order 26.4b1 NJ Exec Order 26 than NJ Exe .<br><br>A review of the resident's individual comprehensive care plan (ICCP) did not include a focus area for NJ Exec Order 26.4b1 .<br><br>On 4/24/25 at 12:10 PM during a team interview | F 695 | included to the Resident # 152s individual comprehensive care plan (ICCP) as per physician order (PO).<br>- Physician Order (PO) for NJ Exec Order 26.4b PRN for NJ Exec Order 26.4b1 obtained and placed to the electronic medical records system for the Resident #472.<br>- A focus area, goal and interventions for NJ Exec Order 26 use and NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 were included to the Resident #472s individual comprehensive care plan (ICCP) as per physician order (PO).<br>- The US FOIA (b)(6 that provided treatment/care for the Resident # 472 was educated on following facility policy and procedures on completing Treatment Administration Record (TAR) documentation in electronic medical records system that treatment was completed as ordered.<br><br>II.<br>-All residents have the potential to be affected by the same deficient practice.<br><br>III.<br>-Director of Nursing/Designee completed in-service of all licensed nursing staff on facility policies and procedure on Oxygen Administration, Self-Administration of Medications and recording all provided treatment administration in electronic medical records system to ensure that treatments were administered according to the Physician Orders (PO).<br><br>IV.<br>-Director of Nursing/Designee will perform | |

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| F 695 | Continued From page 15<br>with the administration of the facility, the [US FOIA (b)(6)] [redacted] stated that [NJ Exec Order 26] administration should be care planned.<br><br>A review of the facility's "Comprehensive Care Plans" policy, with a last revised date of 9/2022, included under #6: The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress ...<br><br>N.J.A.C. 8:39-27.1 (a)<br><br>B.) Upon initial tour of the facility on 04/21/2025 at 10:55 AM, the surveyor #2 observed Resident #152 in bed sleeping. The surveyor observed that the resident's [NJ Exec Order 26.4b1] was not labeled with the date in which the [NJ Exec Order] was applied.<br><br>On 04/24/2025 at 09:44 AM, surveyor #2 observed Resident #152 in bed sleeping. The surveyor observed that the resident's [NJ Exec Order 26] [redacted] was not labeled with the date in which the [NJ Exec Order] was applied.<br><br>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: [NJ Exec Order 26.4b1] [redacted].<br><br>A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b1], identified that the resident was [NJ Exec Order 26.4b1] in relation to [NJ Exec Order 26.4b1] | F 695 | full audit of all residents with self-administration of medications order to ensure that all have physician order, care plan and documented self-treatment in electronic medical records system; random audits will be conducted weekly x 4 weeks all residents with self-administration of medications order, if any, will be audited, then monthly for next three (3) months all residents, if any, will be audited .<br>- Director of Nursing/Designee will perform a random audits of the residents on oxygen treatment to ensure that oxygen orders are in place, care planned, and treatments documented according to the Physician Orders (PO); random audits will be conducted weekly x 4 weeks 5 residents with oxygen order will be audited, then monthly for next three (3) months all residents on oxygen will be audited .<br>- Results of the random audits will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 695 | Continued From page 16 | F 695 | | |

for NJ Exec Order 26.4b1.

A review of the resident's individual comprehensive care plan (ICCP) did not identify that the resident requires NJ Exec Order 26.4

A review of the Treatment Administration Record (TAR), dated as of NJ Exec Order 26.4b1, included the following physician orders (PO):

A PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 at 2 NJ Exec Order 26.4b1 via NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1 [ ...].

A PO, dated NJ Exec Order 26.4b1, to NJ Exec Order 26.4b1 weekly and as needed. Every night shift every Sunday. Date and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

During an interview with the surveyor on 04/24/2025 at 10:05 AM, Licensed Practical Nurse (LPN #1) confirmed that resident's NJ Exec Order 26 was to be changed weekly on the Sunday overnight shift and it should be labeled/dated. LPN #1 explained that a resident care plan should have all the information needed to care for a resident. When asked if NJ Exec Order 26 should be on a resident care plan LPN #1 stated, yes and it should have how many NJ Exec Or they are on.

During an interview with the surveyor on 04/24/2025 at 10:23 AM, the US FOIA (b)(6) confirmed NJ Exec Order 26 NJ Exec Order 2 was to be changed weekly and it should be labeled dated when changed. US FOIA (b)(6) acknowledged Resident #152's NJ Exec Order 26 was not on the care plan.

During an interview with the surveyor on

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| F 695 | Continued From page 17<br>04/24/2025 at 11:01 AM, the US FOIA (b)(6) also confirmed that NJ Exec Order 26 should be labeled and dated accordingly.<br><br>During an interview with the surveyor on 04/25/2025 at 09:40 AM, the US FOIA (b)(6) acknowledged NJ Exec Order 26 is to be labeled/dated and should be on resident's care plans.<br><br>A review of the facility's "Comprehensive Care Plan" policy, last updated 09/2022, included the following under Policy Interpretation and Implementation: The Comprehensive Care Plan will describe, at a minimum, the following: A. Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being [ ...]<br><br>A review of the facility's "Oxygen Administration" policy did not identify label or dating of oxygen tubing.<br><br>N.J.A.C. 8:39-27.1 (a)<br>C.) On 4/21/2025 at 10:32 AM, during the initial tour of the facility, Surveyor #3 observed Resident #472 in bed. The resident was receiving NJ Exec Order 26 The resident was also observed holding a NJ Exec Order 26.4b1 ) in their hands and NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was attached to a NJ Exec Order 26.4 located on the bedside table. The NJ Exec Order 26.4b was half-filled with NJ Ex Order 26.4b1 liquid substance and | F 695 | | |

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| F 695 | Continued From page 18<br>connected to a wall-mounted [redacted].<br><br>On 4/22/2025 at 10:52 AM, the resident was observed in bed receiving [redacted] and holding a [redacted] in their left [redacted]. The [redacted] was observed on bedside table containing [redacted] liquid substance.<br><br>On 4/24/2025 at 10:30 AM, a review of the electronic medical record (EMR) revealed the following:<br><br>A review of the Admission Record reflected the resident had diagnoses that included [redacted] and [redacted].<br><br>A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool with target date of [redacted] revealed that it was still in progress.<br><br>A review of the Physician Order (PO) active and discontinued as of [redacted] at 10:30 AM, did not reflect a physician order for [redacted] since admission to the facility. The PO did not also include an order for self-administration of the [redacted] since admission to the facility.<br><br>A review of the Treatment Administration Record (TAR) for the month of [redacted] did not reflect [redacted] administration and [redacted] of the [redacted] since admission.<br><br>A review of Resident #472's individualized care plan did not reveal a focus, goal, and interventions for the resident's [redacted] use and [redacted]. | F 695 | | |

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| F 695 | Continued From page 19<br><br>On 4/24/2025 at 12:08 PM, during an interview with the survey team and in the presence of the [US FOIA (b)(6) redacted] ) stated "Yes" when asked if a physician order was needed for [NJ Exec Order 26 redacted] administration and [NJ Exec Order 26.4b1 redacted]. The [US FOIA (b) redacted] also stated "Yes" when asked if residents who receive [NJ Exec Order 26.4b1 redacted] and residents who [NJ Ex Order 26.4 redacted] themselves needed to be care planned.<br><br>A review of facility-provided policy titled "Oxygen Administration" revised October 2010 included under Preparation 1. Verify that there is a physician's order for this procedure ...2. Review the resident's care plan to assess for any special needs of the resident.<br><br>A review of the facility-provided policy titled "Self-Administration of Medications" revised February 2021 did not address self-administration of suction device. | F 695 | | |
| F 755 SS=D | N.J.A.C. 8:39 - 27.1 (a), (c)(3)<br>Pharmacy Srvcs/Procedures/Pharmacist/Records<br>CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. | F 755 | | 5/23/25 |

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| F 755 | Continued From page 20<br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure accurate accountability of controlled drugs to prevent loss or diversion. The deficient practice was identified for 1 of 5 medication carts inspected.<br><br>This deficient practice was evidenced by the following:<br><br>On 04/23/2025 at 09:59 AM, the surveyor inspected the [redacted] Unit medication cart in the presence of the Registered Nurse #1 (RN#1). | F 755 | I.<br>-All controlled substance medications in all medication carts were re-counted immediately; all controlled substance medications were accounted for.<br>- Registered Nurse #1 was immediately re-educated on facility policy and procedures on Controlled Substances, including the section Dispensing and Reconciling Controlled Substances that,<br>4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing. | |

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| **MERWICK CARE & REHAB CENTER, LLC** | **100 PLAINSBORO ROAD PLAINSBORO, NJ 08536** |

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| F 755 | Continued From page 21<br>A review of the shift-to-shift Narcotic and Controlled Drug Count Verification Record, (NCDCVR) which is used in healthcare settings to track the administration and accountability of controlled substances, revealed missing signatures for the following dates and shifts:<br>04/02/2025 for the outgoing nurse (11:00PM)<br>04/04/2025 for the outgoing nurse (11:00PM)<br>04/06/2025 for the incoming nurse (11:00PM)<br>04/07/2025 for the outgoing nurse (7:00AM)<br>04/09/2025 for the incoming nurse (3:00PM) and outgoing nurse (11:00PM)<br>04/11/2025 for the incoming nurse (3:00PM) and outgoing nurse (11:00PM)<br>04/12/2025 for the outgoing nurse (11:00PM)<br>04/13/2025 for the outgoing nurse (11:00PM)<br>04/14/2025 for the incoming nurse (11:00PM)<br>04/15/2025 for the incoming and outgoing nurse (11:00PM)<br>04/16/2025 for the incoming nurse (3:00PM) and outgoing nurse (11:00PM)<br>04/17/2025 for the outgoing nurse (11:00PM)<br>04/21/2025 for the incoming nurse (3:00PM) and outgoing nurse (11:00PM)<br>04/22/2025 for the incoming nurse (3:00PM) and outgoing nurse (11:00PM)<br><br>During an interview on 04/23/2025 at 09:59 AM with the surveyor, RN #1 said that she was not sure why there were any blanks and that there should not be any blanks on the NCDCVR.<br><br>During an interview on 04/23/2025 at 10:05 AM with the surveyor, the US FOIA (b)(6) said that the NCDVR should be completed at the beginning and end of each shift to ensure accurate narcotic counts and there should not be any blanks.<br><br>During an interview on 04/24/2025 at 12:07 PM | F 755 | II.<br>-All residents have the potential to be affected by the same deficient practice.<br><br>III.<br>-DON/Designee completed in-service of all licensed nursing staff on facility policies and procedure on Controlled Substances, including the section Dispensing and Reconciling Controlled Substances.<br><br>IV.<br>-DON/Designee will perform full audit of the controlled substance logs to ensure full compliance with the facility process; random audits will be conducted weekly x 4 weeks controlled substance logs for all units will be audited, then monthly for next three (3) months controlled substance logs for all units will be audited.<br>- Results of the audits will be presented to the monthly QAPI meeting for review and revision as deemed appropriate. | |

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| F 755 | Continued From page 22<br>with the surveyor, the US FOIA (b)(6) said when the nurses are coming on shift and leaving the shift, they should do an accurate narcotic count and sign off on the NCDVR.<br><br>A review of the facility provided policy, with a revision date November 2022, titled, "Controlled Substances" revealed section "Dispensing and Reconciling Controlled Substances" that, "4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing." | F 755 | | |
| F 812 SS=F | NJAC 8:39-29.7(c)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced | F 812 | | 5/23/25 |

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| F 812 | Continued From page 23<br>by:<br>Based on observation, interview, and review of facility documents, it was determined that the facility failed to a.) sanitize, store, and maintain kitchen equipment to prevent microbial growth, b.) store, label and date potentially hazardous foods to prevent food borne illness, and c.) discard potentially hazardous food past the use by date. The deficient practice was evidenced by the following:<br><br>On 4/21/2025 from 9:36 AM to 10:05 AM, the surveyor, who was accompanied by the US FOIA (b)(6) [redacted], observed the following in the kitchen:<br><br>1. In the walk-in refrigerator, there was a 5-pound container of ricotta cheese with lid ajar and opened date of 4/8/2025. The packaging indicated to use within 7 days of opening. The AFSD confirmed it needed to be discarded.<br><br>2. In the walk-in refrigerator, there were 3 Styrofoam cups of brownish liquid covered with plastic lids with no label and use by date. The US FOIA (b)(6) [redacted] confirmed they were coffee and that they needed to be labeled and dated.<br><br>3. In the walk-in freezer, there were 2 Styrofoam cups of unlabeled and undated frozen whitish substance that the US FOIA (b)(6) [redacted] identified as ice cream. The cups were covered by plastic wrap. The US FOIA (b)(6) [redacted] confirmed they needed to be labeled and dated.<br><br>4. In the dry storage room #2, a dry spillage of whitish powder was noted on top of canned sliced peaches on the lowest shelf. Directly above the cans was a large carton box with whitish powder | F 812 | I.<br>-Five (5)-pound container of ricotta cheese that was located in the walk-in refrigerator was immediately discarded.<br>-Three (3) Styrofoam cups of brownish liquid covered with plastic lids with no label and use by date were immediately discarded.<br>- Two (2) Styrofoam cups of unlabeled and undated frozen whitish substance that the AFSD identified as ice cream were immediately discarded.<br>- A dry spillage of whitish powder that was noted in the dry storage room #2, on top of canned sliced peaches on the lowest shelf was immediately cleaned.<br>- Unlabeled/undated/unsealed plastic bag of whitish powder that AFSD identified as powdered thickener that was located inside a large carton box with whitish powder inside and outside the box, was immediately discarded.<br>-The carton box containing four, 6-pound cans of chocolate pudding was transferred from the floor to the top of other boxes sitting on a shelf immediately.<br>-A 6-pound dented canned sliced apple was immediately discarded.<br>-In the dry storage room #2, a previously opened bag of dry pasta without date was immediately discarded.<br>-An unused conveyor toaster with heavy buildup of reddish brown and black substance all over the catch tray was cleaned immediately.<br>-Fourteen (14) inverted red reusable plastic cups with mouthpiece part down were immediately washed. | |

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| F 812 | Continued From page 24<br>inside and outside the box. Inside the box was an unsealed plastic bag of whitish powder. The [redacted] identified the powder as powdered thickener. The plastic bag was unlabeled and there was no opened or use by date. The [redacted] stated that the powder should have been transferred to another container and the plastic bag sealed. The [redacted] took the box out of the storage room.<br><br>5. In the dry storage room #2, a carton box containing four, 6-pound cans of chocolate pudding was directly on the floor. The [redacted] stated that it should have been 6 inches from the floor. The [redacted] transferred the box on top of other boxes sitting on a shelf.<br><br>6. In the dry storage room #2 on the active can rack, a 6-pound canned sliced apple was observed dented on the side from the upper to the lower seam. The [redacted] confirmed it needed to be discarded.<br><br>7. In the dry storage room #2, a previously opened bag of dry pasta was observed with no opened date. The [redacted] confirmed it needed to be discarded.<br><br>8. On the equipment table, a conveyor toaster not in use was observed with heavy buildup of reddish brown and black substance all over the catch tray. Underneath the conveyor was a heavy buildup of blackish debris. The outer edge of the toaster on the upper and left side had a buildup of greasy brownish substance. The [redacted] stated it would be cleaned.<br><br>9. A vented rolling dish rack containing 14 inverted red reusable plastic cups with | F 812 | -Undated frozen core powder protein shake located in the reach-in freezer was immediately discarded.<br>-An unlabeled big bottle of seltzer in the reach-in refrigerator was immediately discarded.<br>- An unlabeled tub of previously used sandwich spread in the reach-in refrigerator was discarded immediately.<br>-An unlabeled full-size container of ketchup in the reach-in refrigerator was immediately discarded.<br>- Two (2) unlabeled cups of cooked white rice in the reach-in refrigerator were immediately discarded.<br>- One (1) unlabeled covered bowl of milk powder in the reach-in refrigerator was immediately discarded.<br>- An unlabeled container of butter in the reach-in refrigerator was immediately discarded.<br>- A plastic tumbler containing liquid with curdled brownish substance in the reach-in refrigerator was immediately discarded.<br>-An unlabeled plastic bag of bread that appeared to be hard to the touch that located in the reach-in refrigerator was immediately discarded.<br>-Several cartons of milk located in the plastic container in the reach-in refrigerator were immediately discarded.<br><br>II.<br>-All residents have the potential to be affected by the same deficient practice.<br><br>III.<br>- Food Services Director (FSD)/Designee | |

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| F 812 | Continued From page 25<br>mouthpiece part down were stored on top of a floor drain underneath the dish machine conveyor. Dietary aide #1 stated that the staff have finished washing them and the cups were clean.<br><br>On 4/22/2025 at 8:28 AM, the surveyor observed a vented rolling dish rack filled with inverted red reusable plastic cups with mouthpiece part down underneath the dish machine conveyor. The surveyor pointed them out to the US FOIA (b)(6) [redacted] who stated that the cups would be washed again.<br><br>On 4/22/2025 at 9:11 AM, the surveyor and the Licensed Practical Nurse/ Unit Manager (LPN/UM) #1 toured the nourishment room #1 and observed the following:<br><br>1. In the reach-in freezer, an unlabeled and undated frozen core power protein shake. The US FOIA (b)(6) confirmed it needed to be discarded.<br><br>2. In the reach-in refrigerator, a big bottle of seltzer was unlabeled and with no opened date.<br><br>3. In the reach-in refrigerator, a tub of previously used sandwich spread was unlabeled and with no opened date.<br><br>4. In the reach-in refrigerator, a full-size container of ketchup was unlabeled and with no opened date.<br><br>5. In the reach-in refrigerator, two cups of cooked white rice were unlabeled and with no use by date.<br><br>6. In the reach-in refrigerator, one plastic bag of | F 812 | in-serviced all kitchen staff on facility policy and procedures on Food Storage, including Label & Dating, Satellite Kitchen & Nourishment Rooms, Use-by Date topics.<br>- Food Services Director (FSD)/Designee in-serviced all kitchen staff on General Food Preparation and Handling, including, Cleaning Schedule, Dishwashing Procedures, How to Clean and Sanitize Pots/Pans/Utensils/Dishes, Food from Outside Sources topics.<br><br>IV.<br>-Food Services Director (FSD)/Designee will perform a full audit of all items in the walk-in refrigerators and dry storage rooms to ensure that all food items, including opened ones are properly stored, labeled and dated; random audits will be conducted weekly x 4 weeks, then monthly for next three (3) months.<br>-Administrator/Designee will complete a weekly Kitchen Walk Through audit and record the result into electronic audit system for review; audits will be conducted weekly x 4 weeks, then monthly for the next three (3) months.<br>- Results of the audits will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 812 | Continued From page 26 | F 812 | | |

raw oatmeal was unsealed, unlabeled, and with no use by date.

7. In the reach-in refrigerator, one covered bowl of milk powder was unlabeled and with no use by date.

On 4/22/2025 at 9:46 AM, the surveyor and LPN/ UM #2 toured kitchenette #1 and observed the reach-in refrigerator door hsignage that reflected, "all food must be labeled and dated, after 3 days it will be thrown out." The following were also observed:

1. In the reach-in refrigerator, a container of butter was unlabeled and with no opened or use by date. The LPN/ UM #2 confirmed it needed to be discarded.

2. In the reach-in refrigerator, a plastic tumbler containing liquid with curdled brownish substance. The LPN/ UM #2 confirmed it needed to be discarded.

On 4/22/2025 at 9:52 AM, the surveyor and LPN/ UM #3 toured kitchenette #2 and observed the following:

1. In the reach-in refrigerator, a plastic bag of bread that appeared to be hard to the touch, was unlabeled with no opened or use by date.

2. In the reach-in refrigerator, a plastic container with several cartons of milk was immediately taken by the LPN/ UM #3 who stated they needed to be discarded.

3. In the reach-in refrigerator, a take-out style plastic container with leftover food was unlabeled

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| F 812 | Continued From page 27<br>and undated.<br><br>On 4/23/2025 at 8:51 AM, in an interview with the surveyor, the[US FOIA (b)(6) ] stated that the dietary department was responsible for the refrigerators in the kitchenettes. The surveyor relayed to the [US FOIA (b)] the observations from the initial and follow-up tours. The [US FOIA (b)] stated that all foods need to be labeled and dated. The [US FOIA (b)] stated that dented cans need to be discarded. The [US FOIA (b)] stated that all items in storage need to be 6 inches from the floor.<br><br>On 4/25/2025 at 9:30 AM, the[US FOIA (b)(6) ], in the presence of the the [US FOIA (b)(6)] and the survey team, acknowledged the concerns.<br><br>A review of undated facility-provided policy titled "Food Storage" included the following:<br><br>- Under Procedure 7.b.) Food should be dated as it is placed on the shelves if required by state regulation.<br><br>- Under Procedure 7.c.) Date marking will be visible on all high-risk food to indicate the date by which a ready-to-eat, TCS (Time/ Temperature Control for Safety) food should be consumed, sold, or discarded.<br><br>- Under Procedure 8.) Plastic containers with tight-fitting covers must be used for storing grain products, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled and dated.<br><br>- Under Procedure 9.) Food will be stored a minimum of 6 inches above the floor ... | F 812 | | |

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| F 812 | Continued From page 28<br><br>- Under Procedure 11.) Leftover food will be stored in covered containers or wrapped carefully and securely. Each item will be clearly labeled and dated before being refrigerated. Leftover food is used within 7 days or discarded as per the 2017 Federal Food Code.<br><br>- Under Procedure 12.) Refrigerated food storage: f.) All foods should be covered, labeled, and dated.<br><br>- Under Procedure 13.) Frozen Foods: c.) All food items should be covered, labeled, and dated. All foods will be checked to assure that foods will be consumed by their use by dates or discarded.<br><br>A review of undated facility-provided policy titled "General Food Preparation and Handling" included the following:<br><br>- Under Procedure 2.) Food Storage: c.) Food in broken packages, swollen or dented cans with a compromised seal, or food with an abnormal appearance or odor will be discarded.<br><br>- Under Procedure 4.) Food Service: d.) Leftovers must be dated, labeled, covered, cooled, and stored in a refrigerator.<br><br>- Under Procedure 5.) Equipment: a.) All food service equipment should be cleaned, sanitized, air-dried, and reassembled after each use.<br><br>A review of undated facility-provided policy titled "Handling Clean Equipment and Utensils" included the following:<br><br>- Under Procedure: 2.) Clean equipment and | F 812 | | |

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| F 812 | Continued From page 29<br>utensils will be stored in a clean, dry location in a way that protects them from splashes, dust, or other contamination.<br><br>- Under Procedure: 3.) Glasses and cups will be stored in an inverted position on a clean sanitary surface. | F 812 | | |
| F 880 SS=E | N.J.A.C. 8:39 - 17.2 (g)<br>Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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 §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 5/23/25 |

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| F 880 | Continued From page 30<br>but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 880 | | |

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| F 880 | Continued From page 31<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide a sanitary and comfortable environment that helped prevent the development and transmission of communicable diseases and infections. This was identified for 7 of 32 residents reviewed for infection control. The deficient practice was evidenced by the following:<br><br>1.) On 04/24/2025 at 9:55 AM, upon tour of the NJ Exec Order 26.4b1 ), surveyor #1 observed Resident #158 in their bed with an NJ Exec Order 26.4b1 ) sign along the doorframe. The surveyor further observed a black trash bin with self-closing lid inside the resident room next to the door. Inside the room, the surveyor observed the resident trash bin overflowing with personal protective equipment (PPE), specifically blue gowns.<br><br>A review of Resident #158's electronic medical record (EMR) revealed a physician's order to maintain NJ Exec Order 26.4b1 ).<br><br>On the same date at 9:57 AM, the surveyor observed Resident #322 in their bed with an NJ Exec Order 26.4b1 sign along the doorframe. The surveyor further observed a black trash bin with self-closing lid inside the resident room next to the door. Upon entering the room, the surveyor observed dirty gloves and a used NJ Exec Order 26.4b1 laying on top of | F 880 | I.<br>-The Resident # 158's trash bin that was overflowing with personal protective equipment was immediately cleaned and sanitized; the resident was on NJ Exec Order 26.4b1<br><br>- The Resident # 322's trash bin with dirty gloves and a used NJ Exec Order 26.4b1 ) laying on top of used PPE gowns and gloves was immediately cleaned and sanitized; the resident was on NJ Exec Orde<br><br>- RN #1 who was with Resident #25 was immediately in-serviced on facility policies and procedures on Handwashing/Hand Hygiene, Infection Control Protocols, including proper handling of medical equipment, and Medication Administration; RN #1 completed competencies on Handwashing/Hand Hygiene, Handling of Medical Equipment, including blood pressure cuff and pulse oximeter, and Medication Administration after being in-serviced.<br><br>- In the Resident #133's room, the NJ Exec Order 2 containing NJ Exec Orde that was placed next to an open milk container and a cup of liquid with a lid was immediately discarded.<br><br>-The nurse that entered Resident #43's room and flushed the resident's NJ Exec Order 26.4b1 | |

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| | 315001 | A. BUILDING _____ B. WING _____ | C 04/25/2025 |

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

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| F 880 | Continued From page 32<br>used PPE gowns and gloves in the resident's trash bin.<br><br>A review of Resident #322's electronic medical record (EMR) revealed a physician's order to maintain NJ Exec Order 26.4b1 related to, but not limited to, NJ Exec Order 26.4b1.<br><br>During an interview with the surveyor on 04/24/2025 at 10:23 AM, the US FOIA (b)(6) stated that any possible infectious material, including PPE and respiratory equipment, should be tied up in a plastic bag then disposed in the black PPE trash bin located at the doorway.<br><br>During an interview with the surveyor on 04/24/2025 at 11:01 AM, the US FOIA (b)(6) explained that staff are to contain any potentially infection material, including PPE and respiratory equipment, should be in a tied plastic bag then disposed properly. When asked if used suction catheters are to remain unwrapped and visible or if used PPE should be overflowing in resident trash bins the US FO responded, no because it could spread infection.<br><br>During an interview with the surveyor on 04/25/2025 at 09:40 AM, the US FOIA (b)(6) acknowledged that PPE and infectious material should not have been placed in resident trash can.<br><br>A review of the facility's undated "Enhanced Barrier Precautions" policy included the following under Policy Interpretation and Implementation: [ ...]16. Staff are trained prior to caring for residents | F 880 | (NJ Exec Order 26.4b1 ) was immediately in-serviced on facility Infection Control Protocols, including NJ Exec Order 26.4b1<br><br>-The US FOIA (b)(6 who entered Resident #37's room without gown was immediately in-serviced on the facility Infection Control Protocols, including NJ Exec Order 26.4b1<br><br>- The NJ Exec Order 26.4b1 that was found on the floor in the Resident #70's room was immediately discarded.<br><br>- The NJ Exec Order 26.4b1 staff that were visiting Resident #156 were immediately in-serviced on facility Infection Control Protocols, including NJ Exec Order 26.4b1<br><br>II.<br>-All residents have the potential to be affected by the same deficient practice.<br><br>III.<br>-Director of Nursing/Designee completed in-service of all licensed nursing staff, including vascular staff from the vascular company on facility policies and procedure on Handwashing/Hand Hygiene, Infection Control Protocols, including Enhanced Barrie Precautions, and Medication Administration. | |

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| F 880 | Continued From page 33<br>on EBP.<br><br>A review of the facility's undated "Suctioning the Tracheostomy Tube" policy included the following under General Guidelines: [ ...] 28. Disconnect catheter from tubing. Wrap Catheter around gloved hand. Pull the glove off and over the catheter. Discard in designated receptacle. [ ...] 32. Discard personal protective equipment in designated receptacles.<br><br>A review of the facility's undated "Personal Protective Equipment" policy included the following under Policy Interpretation and Implementation: [ ...] 5. Training on the proper donning (putting on), use and disposal of PPE is provided upon orientation and at regular intervals [ ...].<br><br>On 04/22/2025 at 08:49 AM, surveyor #1 completed the Medication Administration Facility Task with Registered Nurse (RN#1) with Resident # 25. The surveyor observed as RN #1 washed their hands with soap and water without fully lathering under the flow of running water for ten seconds .The surveyor then observed RN #1 don (apply) gloves and continue to dispense medication from Resident #25's medication card by obtaining medication card from the cart, popping the medication through the foil backing, picking the pill out of the foil with the gloved hand, and placing in to the medication cup.<br><br>Prior to administering the medication, RN #1 knocked on Resident #25's door, introduced self and surveyor, and advised that she will be administering their medications. RN #1 also informed the resident that their NJ Ex Order 26.4b1 needed to be obtained. RN #1 applied the NJ Exec Order 26.4b1 | F 880 | -Director of Nursing/Designee completed in-service of all licensed nursing staff, on facility policy and procedures on Resident Rights, including the right to a dignified existence and to be treated with respect, kindness and dignity.<br><br>IV.<br>- 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.<br><br>-Director Of Nursing/Designee will perform random observations of interactions with staff members and residents to ensure residents are treated with respect, kindness and dignity; random observations will be conducted weekly x 4 weeks then monthly for (3) three months 5 residents will be observed.<br><br>- Infection Preventionist/Designee will perform random spot checks of the staff handwashing/hand hygiene procedures to ensure compliance; random audits will be conducted weekly x 4 weeks 5 employees will be observed on handwashing/hand hygiene protocol, then monthly for next three (3) months 10 employees will be observed.<br><br>-Director of Nursing/Designee will perform random observations of the medication administration procedures to ensure staffs compliance; random audits will be | |

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| F 880 | Continued From page 34<br>NJ Exec O to the resident's NJ Exec O and applied the NJ Exec Order [redacted] After providing Resident #25's medication and removing her gloves, RN #1 washed their hands with soap and water lathering under the flow of running water for five seconds. RN #1 exited the room and was observed quickly wiping the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 then NJ Exec Order 26.4b1 upon itself. Surveyor #1 did not observe RN #1 NJ Exec Order 26.4b the NJ Exec Order 26.4b1 as the NJ Exec O appeared to dry quickly, allow to air dry, and did not observe RN #1 wipe the monitor screen of the NJ Exec Order 26.4b1.<br><br>When asked how long hand washing should be completed, RN #1 confirmed that it should be 30 seconds with a full lather to ensure that all infections were removed. RN #1 acknowledged that hand washing was not completed for 30 seconds. RN #1 further acknowledged that she should not have used a gloved hand to touch the resident's medication.<br><br>During an interview with the surveyor on 04/24/2025 at 10:23 AM, the US FOIA (b)(6) [redacted] confirmed that it was not best practice to wear gloves during medication pass and that a resident's medication should never be directly touched. The US FOIA (b)(6) further stated that hand washing should last approximately 20 seconds with a full lather.<br><br>During an interview with the surveyor on 04/24/2025 at 11:01 AM, the US FOIA (b)(6) [redacted] also that confirmed that it was not best practice to wear gloves during medication pass, a resident's medication should never be directly touched, hand washing should last approximately 20 seconds with a full lather, | F 880 | conducted weekly x 4 weeks 5 employees will be observed on medication administration protocol, then monthly for next three (3) months 5 employees will be observed.<br><br>- Results of the random observations will be presented to the monthly Quality Assurance Performance Improvement meeting for review and revision as deemed appropriate. | |

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| F 880 | Continued From page 35<br>and that all areas of the blood pressure machine should be disinfected and set out to dry.<br><br>A review of the facility's undated "Handwashing/Hand Hygiene" policy included the following under Washing Hands:[ ...] 2. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers [ ...]<br><br>A review of the facility's undated "Administering Medications" policy included the following under Policy Interpretation and Implementation: [ ...] 25. Staff follows established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precaution, etc.) for the administration of medications, as applicable.<br><br>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."<br><br>NJAC 8:39-33.1(b)<br>2.) On 04/21/2025 at 10:17 AM, Surveyor #2 observed NJ Exec Order 26.4b1 on Resident #133's bedside table. One of the NJ Exec Order 26.4b1. These were placed in close proximity to an actively running NJ Exec Order 26.4b1 and an NJ Exec Order 26.4b1 | F 880 | | |

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| F 880 | Continued From page 36 | F 880 | | |

NJ Exec Order 26.4b1 which was stored in an open plastic bag.

On 04/21/2025 at 10:58 AM, Surveyor #2 observed Resident #49 lying in bed in the bedroom, with a bedside table positioned across the bed. On the table was a NJ Exec Order 26.4b1 placed next to an open milk container and a cup of liquid with a lid.

During an interview with Surveyor #2 on 04/24/2025 at 10:36 AM, the Registered Nurse/Unit Manager #1 said that NJ Exec Order 26 should never be placed on bedside tables, especially near food, beverages, or actively running NJ Ex, due to infection control concerns.

During an interview with Surveyor #2 on 04/24/2025 at 11:00 AM, the US FOIA (b)(6) said that NJ Exec Order 26 not in use should be stored away during meals, and those containing NJ Exec Orde must be kept away from NJ Ex to prevent cross-contamination.

During an interview with Surveyor #2 on 04/24/2025 at 12:24 PM, the US FOIA (b)(6) said that urinals should never be placed on bedside tables, particularly near food, beverages, or NJ Ex, due to infection control risks.

A review of the undated facility provided policy titled, "Resident Rights" revealed that, under the section Policy Interpretation and Implementation, "1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness,

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| F 880 | Continued From page 37<br>and dignity."<br><br>NJAC 8:39-33.1(b)<br>3.) On 04/21/2025 at 10:42 AM during initial tour of the building, surveyor #3 observed a nurse enter Resident #43's room and flush the residents [redacted]. The nurse was not wearing a gown.<br><br>A review of Resident #'s 43 electronic medical record (EMR) revealed a physician's order to maintain [redacted] related to [redacted]<br><br>On 04/22/2025 at 11:33 AM surveyor #3 observed the nurse doing [redacted] on Resident # 37 in their room without a gown on.<br><br>A review of Resident #37's EMR revealed a physician's order to maintain [redacted] related to [redacted]<br><br>During an interview on 04/24/2025 at 10:01 AM with surveyor #3, The [redacted] said when performing direct care with residents on [redacted] they should be wearing gloves, a gown and sometimes a face shield.<br><br>During an interview on 04/24/2025 at 11:02 AM with surveyor #3, the [redacted] said that he does rounds everyday to make sure that staff are wearing the proper PPE when performing care. The [redacted] said for residents on [redacted] staff should be wearing a gown and gloves when providing any direct care. When asked if vital signs and flushing | F 880 | | |

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| F 880 | Continued From page 38<br>a pick would require the nurse the wear a gown, the [redacted] replied, "yes".<br><br>During a review of a facility provided policy titled "Enhanced Barrier Precautions" revealed, "7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply.<br><br>NJAC 8:39-33.1(b)<br><br>4.) On 4/21/25 at 10:08 AM during the initial tour of the facility, surveyor #4 observed an [redacted] in Resident # 70's room with a NJ Exec Order 26.4b1 [redacted] connected to the NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was found on the floor under the bedside table.<br><br>A review of the Admission Record, an admission summary, revealed that Resident #70 had medical diagnoses which included but were not limited to: NJ Exec Order 26.4b1 [redacted]<br><br>A review of the Comprehensive Minimum Data Set (MDS), an assessment tool dated [redacted] identified that the resident had a [redacted] and included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted]. Further review of the MDS revealed the resident was placed on [redacted]. In addition, under section [redacted] Special Treatments, Procedures, and Programs, it was | F 880 | | |

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| F 880 | Continued From page 39<br>indicated that the resident was on [redacted]<br><br>A review of the Physician Order Summary dated as of [redacted], revealed that Resident #70 was prescribed [redacted] to be administered a [redacted] as needed for NJ Exec Order 26.4b1 and to maintain a [redacted]<br><br>During an interview with the survey team on 4/24/25 at 11:02 AM, the US FOIA (b)(6) [redacted] stated that she conducts infection control surveillance on the units. The surveillance process for monitoring [redacted] equipment included checking the functioning of [redacted] equipment, checking for appropriated labeling and storage of [redacted] equipment. When asked how [redacted] equipment should be stored when not in use, the [redacted] stated that [redacted] equipment should be dated and stored in a plastic bag when not in use. The [redacted] added that [redacted] should be changed weekly.<br><br>NJAC 8:39-33.1(b)<br><br>5.) On 4/21/2025 at 10:38 AM, during the initial tour of the facility, Surveyor #5 observed a sign by the door of Resident #156 that the resident was on NJ Exec Order 26.4b1 [redacted], and a Personal Protective Equipment (PPE) bin was outside the resident's room by the doorway. The sign had instructions for staff and visitors to wear gloves and gown during h[redacted] resident activities that included NJ Exec Order 26.4b1 [redacted] | F 880 | | |

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| F 880 | Continued From page 40<br>NJ Exec Ord The surveyor observed 2 visiting staff from a NJ Exec Order 26.4b1 inside the resident's room wearing gloves but no gown. Both visitors were observed NJ Exec Order 26.4b1 the resident in bed, by NJ Exec Order 26.4b their NJ Exec Ord and NJ Exec Orde and NJ Exec Order 26.4b1 their gown exposing the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Visitor #1 was observed operating the NJ Exec Order 26.4b1 while Visitor #2 stayed by the bedside. When the two visitors concluded their visit, Surveyor #4 asked them if they should have worn gowns as indicated in the NJ Exec Or signage. Visitor #1 stated they did not know that they had to wear gown.<br><br>A review of the Admission Record revealed Resident #156 was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1<br><br>A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, reflected the resident had a NJ Exec Order 26.4b1 .<br><br>A review of the Clinical Physician Orders active as of NJ Exec Order 26.4b1 revealed an order for NJ Exec Order 26.4b1 for NJ Exec Order 26.4 every shift started on NJ Exec Order 26.4b1<br><br>A review of the comprehensive care plans initiated on NJ Exec Order 26.4b1, reflected a focus for NJ Exec Or related to NJ Exec Order 26.4b1. Interventions included the following: Staff will wear gown and gloves during NJ Exec Order 26.4b1 care like NJ Exec Order 26.4b1 | F 880 | | |

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| F 880 | Continued From page 41<br>NJ Exec Order 26.4b1 Use of signage to identify resident that requires [redacted]<br><br>On 4/24/2025 at 11:01 AM, during an interview with the survey team, the US FOIA (b)(6) [redacted] stated that visitors like the staff from the vascular company who did an NJ Exec Order 26.4b1 test on the resident need to observe [redacted] if they have NJ Exec Order 26.4b1 with a resident on [redacted]<br><br>A review of the facility-provided policy titled "Enhanced Barrier Precautions" revised in December 2024, included under Policy Interpretation and Implementation 7.a) Gloves and gown are applied prior to performing the high contact resident care activity. 8.) Examples of high-contact resident care activities requiring the use of gown and gloves for EBP include ...f.) providing bed mobility ...h.) prolonged, high-contact with ...resident's clothing or skin.<br><br>N.J.A.C. 8:39 - 19.4 (a) | F 880 | | |

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| S 000 | Initial Comments<br><br>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<br><br>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for the 2 weeks of staffing prior to survey from 4/6/25 to 4/25/25, the facility was deficient CNA staffing for 14 of 14-day shifts.<br><br>Findings include:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for | S 560 | I.<br>-Facility is aggressively hiring nursing staff to meet State staffing requirements.<br>-Facility facilitates Open House/Job Fair events as scheduled.<br>-Facility utilizes advanced employment search engines to advertise openings for certified nursing assistant positions, including job fairs with immediate interviews and contingency offers for all licensed nursing staff, including CNAs.<br>-Facility implemented shift differential pay structure for 3-11 and 11-7 shifts.<br>-Facility implemented signed-on and referral bonus structures for the CNAs to | 5/23/25 |

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

Electronically Signed | 05/16/25

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 11103L | A. BUILDING: _____ B. WING _____ | C 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERWICK CARE & REHAB CENTER, LLC | 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) COMPLETE DATE |
|---|---|---|---|---|
| S 560 | Continued From page 1<br>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 02/01/2021:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>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<br><br>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.<br><br>For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:<br><br>-04/06/25 had 12 CNAs for 162 residents on the day shift, required at least 20 CNAs.<br>-04/07/25 had 14 CNAs for 162 residents on the day shift, required at least 20 CNAs.<br>-04/08/25 had 16 CNAs for 162 residents on the day shift, required at least 20 CNAs.<br>-04/09/25 had 14 CNAs for 162 residents on the day shift, required at least 20 CNAs.<br>-04/10/25 had 15 CNAs for 162 residents on the day shift, required at least 20 CNAs.<br>-04/11/25 had 12 CNAs for 164 residents on the day shift, required at least 20 CNAs.<br>-04/12/25 had 13 CNAs for 164 residents on the day shift, required at least 20 CNAs. | S 560 | attract and retain candidates.<br>-Facility utilizes a Corporate Recruiter (CP) who is scouting through the local CNA schools to recruit newly graduated certified nursing assistants.<br><br>II.<br>-All residents have the potential to be affected by the same deficient practice.<br><br>III.<br>-HR/Designee re-educated nursing staff on facility Attendance policy and procedures, including call out policy to reduce number of call outs.<br>- DON/Staffing Coordinator will meet daily to review all callouts to proactively make every effort to replace and/or substitute staff members.<br>-Facility implemented two (2) advanced software On Shift and UKG Proto simplify the scheduling process and to update real time to match with SBV payroll system.<br>-Facilitys Master Schedule is in place, updated real time and posted for CNAs to follow.<br>-DON/Staffing Coordinator will meet with the Administrator daily to discuss the staffing schedule for the day and following 3-5 days.<br>-Facility has 24-hour nursing management on-call rotation in case of any call outs and/or to cover the floor if needed.<br>-Facility utilizes reinforcement steps for excessive call outs if any.<br><br>IV.<br>-DON/Designee will monitor/audit staffing ratios until requirements are met; the results of the audits will be forwarded to | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 11103L | A. BUILDING: _____ B. WING _____ | C 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| S 560 | Continued From page 2<br><br>-04/13/25 had 10 CNAs for 164 residents on the day shift, required at least 20 CNAs.<br>-04/14/25 had 11 CNAs for 166 residents on the day shift, required at least 21 CNAs.<br>-04/15/25 had 15 CNAs for 166 residents on the day shift, required at least 21 CNAs.<br>-04/16/25 had 11 CNAs for 166 residents on the day shift, required at least 21 CNAs.<br>-04/17/25 had 12 CNAs for 166 residents on the day shift, required at least 21 CNAs.<br>-04/18/25 had 14 CNAs for 164 residents on the day shift, required at least 20 CNAs.<br>-04/19/25 had 10 CNAs for 164 residents on the day shift, required at least 20 CNAs.<br><br>For the 2 weeks of AAS-12 staffing, the facility was deficient in staffing for required resident services on 3 of 14 days as follows:<br><br>For the week of 04/06/25<br>Required Staffing Hours: 445.25<br><br>-04/06/25 had 432 actual staffing hours, for a difference of -13.25 hours.<br><br>For the week of 04/13/25<br>Required Staffing Hours: 451.50<br><br>-04/13/25 had 424 actual staffing hours, for a difference of -27.50 hours.<br>-04/19/25 had 416 actual staffing hours, for a difference of -35.50 hours.<br><br>During an interview with the surveyor on the 4/24/25 at 9:19 AM, the Staffing Coordinator (SC) was asked if she was familiar with the minimum staffing requirements for CNA's. The SC replied, yes, 1 CNA to 8 residents on the day shift, 1 CNA | S 560 | the facility Administrator and monthly QAPI Committee for review and revision as deemed appropriate; audits will be conducted weekly x 4 weeks 2 audits, then monthly for next three (3) months 3 audits, and as needed.<br>-The Human Resources Director (HR)/Designee will report recruitment and retention trends, outcomes, and recommendations to the QAPI Committee meetings monthly for 3 months, then quarterly x 9 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 |
|---|---|---|---|
| | 11103L | A. BUILDING: _____ B. WING _____ | C 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| S 560 | Continued From page 3<br>to 10 residents in the evening and 1 CNA to 14 residents for the night shifts. When asked are you meeting the requirements, and the SC said, "We don't always meet the requirements of the day shifts."<br><br>On 4/28/25 at 10:49 AM, the surveyor reviewed an undated facility policy titled, "Staffing-New Jersey." The policy identified under, Minimum Staffing Requirements for Nursing Homes-NJ 30:13-18, the following minimum direct care staff to resident ratios:<br>1. Day shift: one (1) CNA to every eight (8) residents.<br>2. Evening shift: one (1) direct care staff member to every ten (10) residents, provided that no fewer than half members are CNAs, and each staff member shall be signed in to work as a CNA and perform CNA duties.<br>3. Night shift: one (1) direct care staff member to every fourteen (14) residents, provided that each direct care staff sign in to work as a CNA and perform CNA duties. | S 560 | | |

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<br>B. Wing Y2 | 6/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERWICK CARE & REHAB CENTER, LLC | 100 PLAINSBORO ROAD<br>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 F0550 | Correction | ID Prefix F0584 | Correction | ID Prefix F0640 | Correction |
| Reg. # 483.10(a)(1)(2)(b)(1)(2) | Completed | Reg. # 483.10(i)(1)-(7) | Completed | Reg. # 483.20(f)(1)-(4) | Completed |
| LSC | 05/23/2025 | LSC | 05/23/2025 | LSC | 05/23/2025 |
| ID Prefix F0658 | Correction | ID Prefix F0695 | Correction | ID Prefix F0755 | Correction |
| Reg. # 483.21(b)(3)(i) | Completed | Reg. # 483.25(i) | Completed | Reg. # 483.45(a)(b)(1)-(3) | Completed |
| LSC | 05/23/2025 | LSC | 05/23/2025 | LSC | 05/23/2025 |
| ID Prefix F0812 | Correction | ID Prefix F0880 | Correction | ID Prefix | Correction |
| Reg. # 483.60(i)(1)(2) | Completed | Reg. # 483.80(a)(1)(2)(4)(e)(f) | Completed | Reg. # | Completed |
| LSC | 05/23/2025 | LSC | 05/23/2025 | 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** 4/25/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 11103L Y1 | A. Building<br>B. Wing Y2 | 6/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERWICK CARE & REHAB CENTER, LLC | 100 PLAINSBORO ROAD<br>PLAINSBORO, NJ 08536 |

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 05/23/2025 | 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 | |
|---|---|
| 4/25/2025 | ☐ 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**<br>B. WING _____ | **04/25/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MERWICK CARE & REHAB CENTER, LLC** | **100 PLAINSBORO ROAD**<br>**PLAINSBORO, NJ 08536** |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>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 | | |
| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 4/24/25, 4/25/25 and 4/28/25 and Merwick Care and Rehabilitation Center was found to be in non-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.<br><br>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.<br>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 271<br>SS=E | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>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 | K 271 | | 5/23/25 |

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

Electronically Signed | 05/16/2025

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 |
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| | 315001 | A. BUILDING 02<br>B. WING _____ | 04/25/2025 |

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|---|---|---|---|---|
| K 271 | Continued From page 1<br>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<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and interviews on 4/24/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to maintain a stable, level walking surface at exit discharge for 2 of 13 exterior exits in accordance with NFPA 101: 2012 Edition, Section 7.7, 7.1.6.2, 7.1.10.1, 19.2.7. This deficient practice had the potential to affect 59 of 162 residents and was evidenced by the following:<br><br>Observations at 12:25 PM of the stairwell G exit revealed the concrete walk from the exit to the public way posed a trip hazard in the path of egress for evacuation. There was a 3-1/2 foot by 10 to 12-inch wide patch in the 5 foot wide concrete path that was deteriorated.<br><br>Observations at 1:11 PM of stairwell A exit revealed the concrete walk from the exit to public way posed a trip hazard in the path of egress for evacuation. There were three places that the concrete was deteriorated in the walkway.<br><br>In interviews at the times, the US FOIA (b)(6) confirmed the observations.<br><br>The facility's US FOIA (b)(6) [redacted]) were informed of the deficient practice at the Life Safety Code exit conference on 4/28/25 at 2:12 PM. | K 271 | I.<br>- 3-1/2 foot by 10 to 12-inch wide patch in the 5 foot wide concrete deteriorated path was located at stairwell G exit concrete walk from the exit to the public way; the deteriorated path was immediately repaired, see attached pictures.<br>- Three (3) places that had deteriorated concrete surface from the stairwell A exit to public way in the path of egress for evacuation were immediately repaired.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Administrator/Designee in-serviced maintenance staff on regulation on Discharge from Exits; Exit discharge shall be maintained free of obstructions.<br><br>IV.<br>Maintenance Director/Designee will complete random audits of all exits to ensure that they are free of obstruction and maintained with stable, level walking surface; audits will be conducted weekly x 4 weeks, then monthly for next three (3) months.<br>- Results of the random observations will be presented to the monthly QAPI | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315001 | A. BUILDING 02<br>B. WING _____ | 04/25/2025 |

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|---|---|---|---|---|
| K 271 | Continued From page 2<br>N.J.A.C 8:39-31.2 (e) | K 271 | meeting for review and revision as deemed appropriate. | |
| K 324 SS=F | Cooking Facilities<br>CFR(s): NFPA 101<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* 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<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>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.<br>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<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview on 4/24/25 in the presence of the [redacted], it was determined the facility failed to perform monthly Owners | K 324 | I.<br>- Monthly Owners Inspection of the range-hood wet chemical fire suppression system was completed, see attached picture and added to the monthly | 5/23/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315001 | A. BUILDING 02<br>B. WING _____ | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 324 | Continued From page 3<br>Inspections of the range-hood wet chemical fire suppression system in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all residents and was evidenced by the following:<br><br>An observation at 12:51 PM of the kitchen range-hood wet chemical fire suppression system inspection tag, revealed the semi-annual inspection was performed in April 2025 and there were no monthly inspections listed on the back of the tag. The facility did not have documentation indicating the monthly Owners Inspection had been performed during the last 12 months.<br><br>In an interview at the time, the US FOIA (b)(6) confirmed the observation and the US FOIA stated they did not perform an Owners Inspection.<br><br>The facility's US FOIA (b)(6), the US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 4/28/25 at 2:12 PM.<br><br>N.J.A.C 8:39-31.1(c), 31.2 (e)<br>NFPA 96 | K 324 | Preventive Maintenance program.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Administrator/Designee in-serviced maintenance staff on Monthly Owner Inspection of the range-hood wet chemical fire suppression system in accordance with NFPA 17 A.<br><br>IV.<br>- Maintenance Director/Designee will complete monthly required audits and ensure it is filed in the inspection binder to make sure that Monthly Owner Inspections of the range-hood wet chemical fire suppression system are completed in accordance with NFPA 17 A; audits will be conducted monthly x four (4) months, and as needed.<br>- Results of the random observations will be presented to the monthly QAPI meeting for review and revision as deemed appropriate. | |
| K 351 SS=E | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING<br>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 | K 351 | | 6/11/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 315001 | A. BUILDING 02<br>B. WING | 04/25/2025 |

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|---|---|---|---|---|
| K 351 | Continued From page 4<br>Installation of Sprinkler Systems.<br>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.<br>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.<br>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)<br>This REQUIREMENT is not met as evidenced by:<br>Repeat Deficiency<br><br>Based on observation and interview on 4/24/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to install automatic fire sprinklers in accordance with NFPA 101: 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1(1) and NFPA 13 Standard for the Installation of Sprinkler systems, 2010 Edition. This deficient practice has the potential to affect approximately 50 of 162 residents and was evidenced by the following:<br><br>Observations at 1:25 PM of the stairwell B bottom landing where the exterior exit to ground level discharge is located, revealed there was no fire sprinkler protection at the landing under the 4 foot by 8 foot midlevel landing platform from first floor to second floor.<br><br>In an interview at the time, the US FOIA (b)(6) confirmed the observation. | K 351 | I.<br>-Facility scheduled the installation of the fire sprinkler protection unit of the stairwell B bottom landing where the exterior exit to ground level discharge is located, under the 4 foot by 8 foot midlevel landing platform from first floor to second floor; it was scheduled to be installed.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Administrator/Designee in-serviced maintenance staff on construction type requirements on Standard for the Installation of Sprinkler Systems in accordance with NFPA 13.<br><br>IV.<br>- Maintenance Director/Designee will complete weekly follow up regarding | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315001 | A. BUILDING 02<br>B. WING | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERWICK CARE & REHAB CENTER, LLC | 100 PLAINSBORO ROAD<br>PLAINSBORO, NJ 08536 |

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|---|---|---|---|---|
| K 351 | Continued From page 5<br>The facility's US FOIA (b)(6), the US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 4/28/25 at 2:12 PM.<br><br>This deficient practice was cited on the last Standard Recertification survey dated 11/22/2023.<br><br>N.J.A.C 8:39-31.2 (e)<br>NFPA 13 | K 351 | installation and record all communications/follow-ups into the maintenance audit form.<br>-Maintenance Director/Designee will communicate progress on installation to the Administrator weekly.<br>-Once the sprinkler head is installed, Maintenance Director/Designee will continue routine check on all facility sprinkler heads as a part of the weekly inspections; audits will be conducted weekly for four (4) weeks, then monthly x four (4) months, and as needed.<br>- Results of the random observations will be presented to the monthly QAPI meeting for review and revision as deemed appropriate. | |
| K 531 SS=F | Elevators<br>CFR(s): NFPA 101<br><br>Elevators<br>2012 EXISTING<br>Elevators comply with the provision of 9.4.<br>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.<br>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 | K 531 | | 5/23/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315001 | A. BUILDING 02<br>B. WING _____ | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MERWICK CARE & REHAB CENTER, LLC | 100 PLAINSBORO ROAD<br>PLAINSBORO, NJ 08536 |

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| K 531 | Continued From page 6<br>elevator lobby smoke detectors.)<br>19.5.3, 9.4.2, 9.4.3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview on 4/24/25 and 4/25/25 in the presence of the US FOIA (b)(6) [redacted]), it was determined the facility failed to perform monthly firefighters service requirement testing for 5 of 5 elevators in accordance with NFPA 101: 2012 Edition, Section 19.5.3, 9.4.2 and 9.4.3. This deficient practice has the potential to affect 162 residents and was evidenced by the following:<br><br>Observation on 4/24/25 at 10:15 AM of the elevator room for elevators P1 and P2 revealed the elevator service logs that contained documentation of the monthly firefighters Phase 1 and phase 2 operation tests. The tests were performed and documented for the months of: February, March and April 2025. There was no documentation of the firefighters monthly tests for the previous 9 months from April 2024 to January 2025.<br><br>Observations on 4/24/25 at 11:03 AM of the elevator room for elevators SE2 and PE3, revealed the elevator service logs that contained documentation of the monthly firefighters Phase 1 and phase 2 operation tests. The tests were performed and documented for the months of: February, March and April 2025. There was no documentation of the firefighters monthly tests for the previous 9 months from April 2024 to January 2025.<br><br>In interviews at the times, the US FOIA (b)(6) [redacted] confirmed the observation. | K 531 | I.<br>-Facility hired a new elevator company Signature Elevator in NJ Exec Order 26.4b1; since NJ Exec Order 26.4b1 all required elevator inspections are completed based on the State and Federal deadline requirements.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Administrator/Designee in-serviced maintenance staff on adhering to the required deadlines on completion of the monthly elevator inspections based on provision of 9.4 Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators.<br><br>IV.<br>- Maintenance Director/Designee will complete random audits of inspection binder to make sure that Monthly Elevator Inspections are completed in accordance with ASME A17.1, Safety Code for Elevators and Escalators.; audits will be conducted monthly x four (4) months, and as needed.<br>- Results of the random observations will be presented to the monthly QAPI meeting 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**<br>B. WING _____ | **04/25/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MERWICK CARE & REHAB CENTER, LLC** | **100 PLAINSBORO ROAD**<br>**PLAINSBORO, NJ 08536** |

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| K 531 | Continued From page 7<br><br>Record review on 4/25/25 of the annual elevator inspection certificated revealed 5 temporary certificates dated to expire on 5/20/25. There were no documents for the 2024 monthly firefighters Phase 1 and Phase 2 operation tests.<br><br>In an interview at the time, the [redacted] confirmed the record review and stated that the facility changed elevator service companies in January 2025 and he cannot get documents from the previous company.<br><br>The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 4/28/25 at 2:12 PM. | K 531 | | |
| K 761 SS=F | N.J.A.C 8:39-31.2 (e)<br>Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80) | K 761 | | 5/23/25 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315001 | A. BUILDING 02<br>B. WING | 04/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 761 | Continued From page 8<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview on 4/24/25 and 4/28/25 in the presence of the [redacted], it was determined the facility failed to ensure fire door assemblies were inspected and tested annually for 14 of 14 fire doors in accordance with NFPA 101: 2012 Edition, Section 8.3.3.1 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 162 residents and was evidenced by the following:<br><br>Observations on 4/24/25 between 9:43 AM and 2:00 PM revealed there were 13 exit stairwell enclosure fire doors and 1 occupancy separation fire wall fire door.<br><br>Record review on 4/28/25 revealed there was no documentation of the stairwell fire doors test and inspection in the smoke door inspection log provided.<br><br>In an interview on 4/28/25 at 1:20 PM, the [redacted] confirmed the record review and stated the facility will add the fire doors to the door inspection log.<br><br>The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 4/28/25 at 2:12 PM.<br><br>N.J.A.C 8:39-31.2 (e)<br>NFPA 80 | K 761 | I.<br>- The stairwell fire door was immediately added to the monthly and annual fire doors inspection list; it was inspected and in compliance, see attached picture.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Administrator/Designee in-serviced maintenance staff on NFPA 80, Standard for Fire Doors and Other Opening Prospective, including requirements for testing all facility fire doors in accordance with NFPA 101:2012 Edition, Section 8.3.3.1 and NFPA 80:2010 Edition.<br><br>IV.<br>- Maintenance Director/Designee will complete random audits of 14 fire doors monthly; audits will be conducted monthly x four (4) months, and as needed.<br>- Results of the random observations will be presented to the monthly QAPI meeting for review and revision as deemed appropriate. | |
| K 918<br>SS=F | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101 | K 918 | | 5/30/25 |

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|---|---|---|---|
| | 315001 | A. BUILDING **02**<br>B. WING _____ | **04/25/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MERWICK CARE & REHAB CENTER, LLC** | **100 PLAINSBORO ROAD**<br>**PLAINSBORO, NJ 08536** |

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| K 918 | Continued From page 9<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview on 4/25/25 in the presence of the US FOIA (b)(6) | K 918 | I.<br>-An annual generator diesel fuel quality | |

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|---|---|---|---|
| | 315001 | A. BUILDING **02**<br>B. WING _____ | **04/25/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 918 | Continued From page 10<br>([redacted] it was determined the facility failed to perform a diesel fuel quality test annually in accordance with NFPA 110: 2010 Edition, Section 8.3.8. This deficient practice has the potential to affect 162 residents and was evidenced by the following:<br><br>A record review of the generator service reports revealed there was no fuel sample taken for quality analysis in the last 12 months.<br><br>In an interview at the time, the [redacted] confirmed the findings.<br><br>The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 4/28/25 at 2:12 PM.<br><br>N.J.A.C 8:39-31.2 (e)<br>NFPA 99, 110 | K 918 | test was immediately scheduled and completed on 5/9/25, pending result.<br><br>II.<br>-All residents have the potential to be affected by this deficient practice.<br><br>III.<br>-Administrator/Designee in-serviced maintenance staff on NFPA 110:2010 Edition, Section 8.3.8, including annual generator diesel fuel quality test.<br><br>IV.<br>- Maintenance Director/Designee will complete random audits of inspection binder to make sure that annual generator fuel quality test is completed in accordance with NFPA 110; audits will be conducted monthly x four (4) months, and as needed.<br>- Results of the random observations will be presented to the monthly QAPI meeting for review and revision as deemed appropriate. | |

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<br>B. Wing Y2 | 6/13/2025 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MERWICK CARE & REHAB CENTER, LLC | 100 PLAINSBORO ROAD<br>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 K0271 | 05/23/2025 | LSC K0324 | 05/23/2025 | LSC K0351 | 06/11/2025 |
| ID Prefix | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed | Reg. # NFPA 101 | Completed |
| LSC K0531 | 05/23/2025 | LSC K0761 | 05/23/2025 | LSC K0918 | 05/30/2025 |
| 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? |
|---|---|
| 4/25/2025 | ☐ YES ☐ NO |