STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ155672, NJ159535, NJ161374, NJ161777, NJ163444, NJ163448, NJ163626, NJ164589, NJ164590 CENSUS: 148 SAMPLE SIZE: 15 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F728IJ Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, and 6/7/2023, it was determined that the facility failed to ensure a process was in place and followed to ensure untrained staff without sufficient competencies were meeting the health and/or safety needs of one or more residents. Hospitality Aides (HAs), which include (Certified Home Health Aides-CHHAs and Temporary Nurses' Aides-TNAs), were competent to provide Resident care by failing to ensure: a.) HAs were enrolled in a State-approved training and competency program, and b.) a system was in place to ensure all HAs received the appropriate training and were deemed eligible to provide resident care, which included, but was not limited to, assisting residents with toilet care, bathing and turning and repositioning residents. On 6/5/2023	F 000		

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

Electronically Signed | 07/24/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

at 11:28 a.m., the Surveyor observed an HA (HA #1) assist a resident (Resident #2) from the bathroom with his/her walker and then transferred the Resident from a standing position to a sitting position into a chair in the corner of the room. During an interview on 6/5/2023 at 11:29 a.m., the HA said she had [redacted] residents today, all total care, and she does the same duties as the Certified Nursing Assistant (C.N.A.). On 6/5/2023 at 6:42 p.m., the Surveyor observed HA #2 assisted CNA #1 with bathing when she helped reposition a resident (Resident #7) in bed.

The facility's failure to have a system in place to ensure that HAs were appropriately trained and certified to provide resident care placed all residents at risk for the likelihood that serious injury, serious harm, and death may occur, resulting in an Immediate Jeopardy situation (IJ). This placed all residents in an IJ situation. The IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (D.O.N.) on 6/5/2023 at 8:00 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 6/5/2023 and continued through 6/7/2023, when the facility removed all HAs from the floor.

On 6/7/2023, the Removal Plan was implemented. The facility implemented the Removal Plan, which included removing all uncertified aides [H.A.s] from the floor and educating all staff that uncertified aides [H.A.s] are not to be in resident care areas. So, the noncompliance remained on 06/7/2023 as a level F for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2	F 000		

F835IJ

Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, and 6/7/2023, it was determined that the facility failed to ensure a process was in place and followed to ensure untrained staff without sufficient competencies were meeting the health and/or safety needs of one or more residents. Hospitality Aides (HAs), which include (Certified Home Health Aides-CHHAs and Temporary Nurses' Aides-TNAs), were competent to provide Resident care by failing to ensure: a.) HAs were enrolled in a State-approved training and competency program, and b.) a system was in place to ensure all HAs received the appropriate training and were deemed eligible to provide resident care, which included, but was not limited to, assisting residents with toilet care, bathing and turning and repositioning residents. On 6/5/2023 at 11:28 a.m., the Surveyor observed an HA (HA #1) assist a resident (Resident #2) from the bathroom with his/her walker and then transferred the Resident from a standing position to a sitting position into a chair in the corner of the room. During an interview on 6/5/2023 at 11:29 a.m., the HA said she had 18 residents today, all total care, and she does the same duties as the Certified Nursing Assistant (C.N.A.). On 6/5/2023 at 6:42 p.m., the Surveyor observed HA #2 assisted CNA #1 with bathing when she helped reposition a resident (Resident #7) in bed. The Administrator failed to follow the facility policy titled "Employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 3 Care Partner Hiring Policy" and the job description titled "Administrator." The facility's failure to have a system in place to ensure that HAs were appropriately trained and certified to provide resident care placed all residents at risk for the likelihood that serious injury, serious harm, and death may occur, resulting in an Immediate Jeopardy situation (IJ). This placed all residents in an IJ situation. The IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (D.O.N.) on 6/5/2023 at 8:00 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 6/5/2023 and continued through 6/7/2023, when the facility removed all HAs from the floor. On 6/7/2023, the Removal Plan was implemented. The facility implemented the Removal Plan, which included removing all uncertified aides [H.A.s] from the floor and educating all staff that uncertified aides [H.A.s] are not to be in resident care areas. So, the noncompliance remained on 06/7/2023 as a level F for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: C#: NJ#163626, NJ#164589	F 641	I.	7/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 Based on interviews and review of other pertinent facility documents on 6/8/23 and 6/9/23, it was determined that the facility failed to complete the Minimum Data Set (MDS), an assessment tool, accurately and also failed to follow its facility policy titled "Resident Assessment - (resident assessment instrument) RAI," for 4 of 15 sampled residents (Resident #3, Resident #4, Resident #5, and Resident #15). This deficient practice was evidenced by the following: During a tour of the facility on 6/8/23 at 9:18 AM, the surveyor observed Resident #8 with an [redacted] was saturated with urine. The Certified Nursing Assistant (CNA) stated all incontinent residents should be changed at 6 AM during the previous shift. The CNA was unable to determine whether the Resident was changed at 6 AM. Review of the Electronic Medical Records (EMR) were as follows: 1. According to the "Face Sheet," Resident #3 was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the "Physician's Orders (PO)" as of [redacted] did not show an order for incontinence care, nor had a diagnosis of [redacted] for Resident #3. The "Care Plan (CP)" dated [redacted] indicated Resident #3 had a Self-Care Performance Deficit and required [redacted] assistance	F 641	- Minimum Data Set (MDS) modifications for Resident #3, Resident #4, and Resident #15 completed; Resident #8 discharged on [redacted] - Resident #3: BIMS was completed on 6/13/23 by the psychologist; BIMS score was [redacted] which indicated resident was [redacted]. In addition, psychologist stated that "resident had been followed by [redacted] clinician last year and resident can speak enough [redacted] to participate in interview and therapy." On 6/12/23, the Care Plan (CP) for Resident #3 was updated to include [redacted] care. In addition, the task for [redacted] care was added to Activities of Daily Living (ADL) flow sheet for all licensed nursing staff. - Resident #4: on [redacted] diagnosis for [redacted] was added to electronic medical record (EMR); CP was updated to indicate [redacted]; Physician Order (PO) for [redacted]" was discontinued. The CP was also updated to include [redacted] care. In addition, the task for [redacted] care was added to ADL binder for all licensed nursing . Resident was reassessed for [redacted] and placed on 3-day toileting schedule; Treatment Administration Record (TAR) was updated. - Resident #8: [redacted] resident immediately received [redacted] care. Resident was discharged from the facility on [redacted] - Resident #15: On [redacted] modification was completed for MDS ARD [redacted] to capture [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 with [redacted] The CP also revealed Resident #3 was not care planned for [redacted] care. A review of the "Treatment Administration Record (TAR)" dated [redacted] revealed no orders for [redacted] care. A review of Resident #3's Progress Notes (PNs), dated [redacted], did not address [redacted]. According to the Quarterly MDS, dated [redacted] Resident #3 had a Brief Mental Interview for Mental Status (BIMS), a cognitive assessment, which indicated the Resident was [redacted]."The MDS showed Resident #3 was an [redacted] and/or [redacted] on Activities of Daily Living (ADLs), specifically transfers, bed mobility, toilet use, and personal hygiene. The MDS also revealed Resident #3 was always [redacted]. Resident #3 was able to communicate clearly with the surveyor with a [redacted] speaking [redacted]. Resident #3 was [redacted], but able to answer all questions asked by the surveyor. Resident was able to articulate his/her status, his/her [redacted] and the type of care he/she received daily. During a facility tour on 6/8/23 at 9:45 AM, the surveyor observed Resident #3 in a chair in the common area. The resident stated she/he had gotten up that morning and changed his/her [redacted] by himself/herself by [redacted]. The Resident stated he/she needed to get [redacted] as soon as he/she goes to the	F 641	[redacted] Resident #15 was discharged from the facility on [redacted] and was no longer active resident during the time of the Department of Health (DOH) Complaint visit on 06/05/2023. II. - All residents have the potential to be affected by the same deficient practice. III. - ADON/Designee will check all current facility residents' assessments for accuracy on diagnoses, MDS coding, and appropriate care plans that reflect residents' needs and status. - MDS Coordinator(s) were in-serviced on correct coding of assessments. - Facility Educator in-serviced Director of Social Services on appropriate use of interpreter as needed to complete MDS; in-services started on 6/12/23. - Nursing Staff were in-serviced on facility policies and procedures on initiating base line and completing comprehensive care plans for admitted residents as well as facility policy and procedures on [redacted] Care and Interventions; in-services started on 6/12/23. - Facility Educator/Designee will continue in-services for MDS coordinator(s) on facility policies and procedures on accuracy on diagnoses, MDS coding, and appropriate care plans that reflect residents' needs and status. - Facility Educator/Designee will continue in-services for nursing staff on facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 bathroom because "it irritates his/her [redacted] Resident #3 stated the CNAs change him/her [redacted] times daily. Resident #3 stated she is [redacted]. 2. According to the "Face Sheet," Resident #4 was admitted to the facility with diagnoses that included but were not limited to acquired absence of [redacted]. In a review of Resident 4#'s "PNs," dated [redacted] the physician noted the Resident had a "[redacted]) on [redacted] for a [redacted] According to the Comprehensive MDS, dated 10/4/22, Resident #4 had a BIMS score of [redacted] which indicated the Resident was [redacted] Under "[redacted] and [redacted]," Resident #4 was coded under A. Moving from [redacted] position as 2 - [redacted], only able to [redacted] assistance; under B. Walking - 8 - activity did not occur; under C. [redacted] the opposite direction while walking - 8 activity did not occur; under D. [redacted]t - 2 [redacted]; and E. [redacted] (transfer between bed and chair or wheelchair) - 2 - [redacted] assistance. Under Mobility Devices, Resident #4	F 641	policies and procedures on initiating base line and completing comprehensive care plan, for admitted residents as well as facility policy and procedures on [redacted] Care and Interventions. IV. - ADON/Designee will conduct random audit for all incontinence residents to ensure that all have proper diagnosis for incontinence, MD orders, [redacted] care plan, and task for [redacted] care in the ADL flow sheet; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - MDS Coordinator/Designee will conduct random audit for all [redacted] residents to ensure proper coding for [redacted], and diagnosis; MDS Coordinator will place MDS modifications if any incorrect coding identified; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot audits on proper [redacted] diagnosis, care plans, MD orders, MDS' and tasks in the ADL flow sheets; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 was marked for B. [redacted] and C. [redacted]. According to the most recent Quarterly MDS, dated [redacted], Resident #4 had a BIMS score of [redacted] which indicated the Resident was [redacted]. The MDS showed Resident #4 was a [redacted] for most ADLs and had [redacted]. The MDS also revealed Resident #4 was always [redacted] A review of Resident #4's "PO" dated [redacted] did not show a diagnosis for [redacted] of the [redacted], and there was no order for [redacted]. Also on the PO was an order for "[redacted] every shift for [redacted] care." The "CP" dated [redacted] and revised 4/18/23 indicated Resident #4 had a risk for [redacted] related to [redacted] problems. The CP dated [redacted] and revised [redacted] revealed Resident#4 had [redacted] related to a [redacted]. The CP dated [redacted] and revised [redacted] revealed Resident #4 had [redacted], related to a [redacted] and [redacted]. The resident was marked on the MDS as [redacted], but had an [redacted] on at the time of observation that was [redacted]. The resident stated [redacted]. 3. According to the "Face Sheet," Resident #8 was admitted to the facility with diagnoses that included but were not limited to: [redacted]	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

According to the Comprehensive MDS, dated Resident #8 had a BIMS of which indicated the Resident had The MDS showed Resident #8 was an with most ADLs, specifically The MDS also revealed Resident #8 was always and

A review of the "PO" dated had no diagnosis of and no orders for .

The "CP" dated indicated Resident #8 had no CP for care.

A review of the "TAR" dated revealed no order for care.

A review of Resident #8's "PNs," dated revealed Resident was r and A PN on revealed noted in " but did not mention at this time. A PN dated revealed the Resident is all or most of the time.

The MDS revealed Resident #8 was always , however the progress notes indicated the resident was . The resident was wearing an at the time of observation that had in it.

During an interview on 6/8/23 at 11:39 AM, the former MDS coordinator reviewed Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9	F 641		

and Resident #4's most current MDS. Resident #3's Quarterly MDS, dated [redacted] was completed using care and progress notes. The MDS coordinator stated she didn't get a chance to interview the Resident; the Social Worker (SW) conducts the interviews with the residents. The surveyor inquired why the Resident was coded as "[redacted]) to the surveyor with an interpreter. The MDS coordinator stated she coded it based on the SW interview and not from actual observation of the Resident.

According to Resident #4's Annual MDS, dated [redacted], the MDS coordinator coded the Resident with a [redacted] on one side based on [redacted] documentation from nursing and rehabilitation. The surveyor informed the MDS coordinator that Resident #4 had an [redacted] or [redacted] and inquired if she would have coded it differently. The MDS coordinator replied, "I would have, but the documentation available stated differently. If I had assessed the Resident, I would have coded it differently."

During an interview on 6/9/23 at 2:15 PM, the DON stated if a resident had a [redacted], that would be considered an [redacted] and it should be coded like that on the MDS.

During a telephone interview on 6/21/23 at 11:48 AM, the SW stated Resident #3's cognitive assessment was based on the questions they would ask on the BIMS. According to the SW, Resident #3 was [redacted] those questions and was coded [redacted], [redacted]." The surveyor asked the SW if Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10	F 641		

#3's assessment was done in [redacted], and she stated, "[redacted] staff in the building." SW also stated psych also completed an assessment on Resident #3 on [redacted], and it was the same result. The surveyor asked the SW if the assessment was done in [redacted], the Resident's [redacted]. She stated she didn't know if it was done in [redacted]. The SW refused to answer any additional questions about Resident #3, #4, and #8's MDS assessments.

4. According to the "Admission Record," Resident #15 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted].

Review of the [redacted] revealed that the facility identified Resident #15 as being [redacted] for developing a [redacted]

Review of Resident #15's Progress Notes (PN) revealed a "Health Status Note," with the effective date of [redacted] at 10:36 PM, that indicated the resident was noted with an [redacted].

Review of Resident #15's [redacted] Injury report (incident report) indicated that the resident was noted with an [redacted] on the [redacted] Under "Immediate Action Taken," indicated that the [redacted] with [redacted]) was applied and covered with [redacted]. Under "Predisposing Physical Factors," indicated that Resident #15 was "[redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11	F 641		

The incident report revealed that the resident's physician and family were notified.

Review of Resident #15's physician "Order Summary Report," (OSR) order date range [redacted] revealed a physician order dated [redacted] with [redacted], and [redacted] that has a [redacted] and [redacted] every day shift for [redacted].

Review of the [redacted] Treatment Administration Record (TAR) revealed the corresponding [redacted] physician order to [redacted] with [redacted], apply [redacted], and [redacted] every "day shift" for [redacted], with the discontinuation date of [redacted]. The TAR included the administration time of "day" shift.

Review of Resident #15's Care Plan (CP) revealed a "Focus," initiated on [redacted] that Resident #13 had potential for [redacted] and [redacted] ... " [redacted], skin is [redacted] noted," The goal, initiated on [redacted], was for Resident #15's to have [redacted] by/through review date. Under "Interventions" reflected to "follow facility policies/protocols for the prevention/treatment of [redacted], prompt [redacted] care, and [redacted] consult as needed."

Review of the annual MDS, dated [redacted], revealed that Resident #15 had [redacted] The MDS also showed that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 12 resident needed [redacted] for bed [redacted] and with [redacted] and [redacted]. The MDS also revealed that the resident was at risk for developing [redacted]. Further review of the MDS showed under "[redacted] "Skin Conditions" (a section used to document the skin conditions of the resident and [redacted] and their [redacted]) showed no documentation that Resident #6 had an [redacted] on the [redacted]. During a telephone interview on 6/9/2023 at 11:41 AM, the MDS Coordinator responsible for completing Resident #15's [redacted] MDS, explained that she normally looked at the resident's CP and physician orders when completing [redacted] of the MDS. The MDS Coordinator reviewed Resident #15's electronic medical record (EMR) and stated that she based the [redacted] coding off the resident's [redacted] report, which indicated the [redacted] was resolved. When questioned about Resident #15's [redacted] physician order to [redacted] "day shift" for [redacted]. The MDS Coordinator reviewed the resident's EMR and stated that she missed the [redacted] 3 physician order. The MDS Coordinator further stated that the wound should have been captured on the [redacted] MDS. Review of the facility's undated "Resident Assessment - RAI" policy revealed the following under "Policy: This facility makes a comprehensive assessment of each Resident's needs, strengths, goals, life history, and preferences using the RAI specified by CMS [Centers for Medicare & Medicaid Services.] Under "Policy Explanation and Compliance	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 13 Guidelines" indicated that "3. The assessment process will include direct supervision and communication with the Resident, as well as communication with licensed and non-licensed direct care staff members on all shifts and under 4. The facility will maintain all resident assessments completed within the previous 15 months in the Resident's active record and use the results of the assessment to develop, review and revise the Resident's comprehensive care plan." N.J.A.C.: 8:39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		7/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ155672 Based on interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, 6/7/2023, 6/8/2023, 6/9/2023 and 6/12/2023, it was determined that the facility failed to implement a baseline care plan (CP) for a resident who was admitted with an [redacted] for 1 of 14 residents (Resident #6). The facility also failed to	F 656	I. - The Resident #6 was discharged from the facility on 6/28/2022 and was no longer active resident during the time of the Department of Health (DOH) Complaint visit on 06/05/2023. II. - All facility residents have the potential to be affected by the same deficient practice. III. - All newly admitted facility residents will have base line care plans within 48 hours	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15 follow its policy titled "Baseline Care Plan." This deficient practice was evident in 1 of 14 care plans, as evidenced by the following: According to the Admission Record (AR), Resident #6 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident # 6 had a Brief Interview of Mental Status (BIMS) score of [redacted], which indicated the Resident was [redacted]. The MDS also showed Resident #6 needed extensive assistance with one-person physical assistance with Transfers and Toilet Use and with most Activities of Daily Living (ADLs). A review of Resident #6's Care Plan (CP) revealed no CP for [redacted]. During a telephone interview on 6/7/2023 at 12:30 p.m., the Unit Manager/Registered Nurse (UM/RN) stated the "purpose of the CP is so that nurses can meet our residents' needs, set goals for them and know how to care for them [residents]." During an interview on 6/9/2023 at 11:00 a.m., the LPN who cared for Resident #6 upon admission stated, "[redacted] care and monitoring the [redacted] should be on the care plan upon admission and updated by the Unit Manager (UM)." The LPN continued to say the UM or the Nurse Supervisor initiates the CP, not	F 656	of admission that meet their initial needs, set goals and interventions, and make nursing staff aware of how to care for the residents. - All active facility residents will have comprehensive care plans that meet their needs, set goals and interventions and make nursing staff aware of how to care for the residents. - All Nursing Licensed Staff were in-serviced on facility policies and procedures on initiating base line within 48 hours of admission and completing comprehensive care plans for admitted residents as per State and Federal Regulations; the care plans must meet all residents' needs, set goals and interventions for them and make nursing staff aware of how to care for residents; education started on 6/12/23. - Facility Educator/Designee will continue in-service on facility policies and procedures on initiating base line for newly admitted residents within 48 hours of admission and completing comprehensive care plans for newly admitted/current residents as per State and Federal Regulations; the care plans must meet all residents' needs, set goals for them and make nursing staff aware of how to care for residents. IV. - ADON/Designee will conduct random audits for current residents to ensure that all newly admitted residents have base line care plan and all current residents have comprehensive care plans that meet residents' needs, set goals and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16 the floor nurse." During an interview on 6/9/2023 at 12:25 p.m., the Director of Nursing (DON) stated, "If a resident [was] admitted with [an] [redacted], [redacted] [the] care of [the] [redacted], [the] [redacted] around the [redacted] [care] and monitor[ing of the] [redacted] should be on the care plan." In the same interview, when the Surveyor asked about the person responsible for the CP, the DON continued to say, "The UM puts it [the [redacted] care] on the CP." During an interview on 6/12/2023 at 1:15 p.m., the Administrator stated the nurses, the UM, and Supervisor are in charge of the CP...[the] UM usually makes sure the CP is done." At the time of the survey, the Unit Manager and Nurse Supervisor who cared for Resident #6 were unavailable for an interview. A review of the facility policy titled "Baseline Care Plan" with a revised date of 2/8/23 revealed the following: Under "Policy" included "The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care ..." Under "Policy Explanation and Compliance Guidelines," included "1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident, including but not limited to: i. Initial goals based on admission orders. ii. Physician Orders ..."	F 656	interventions and make nursing staff aware of how to care for the residents; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot audits on base line/comprehensive care plan completion; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) meetings 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17	F 656		
F 657 SS=E	N.J.A.C. 8:39-27.1 (a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: COMPLAINT: #NJ155672, #NJ163626, #NJ164589	F 657	I. - Revised Comprehensive Care Plans (CP) for Residents #3 and #4 in place.	7/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 18 Based on interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, 6/7/2023, 6/8/2023, 6/9/2023 and 6/12/2023, it was determined that the facility failed to a.) revise the comprehensive Care Plan (CP) for a change in condition for 5 of 15 residents (Resident #3, #4, #6, #8, and #15). The facility failed to follow its policies titled "Change of Condition" and "Comprehensive Care Plans". This deficient practice was evidenced by the following: Review of the Medical Record (MR) was as follows: 1. According to the Admission Record (AR), Resident #3 was admitted to the facility with diagnoses that included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool, dated [redacted] Resident #3 had a Brief Mental Interview for Mental Status (BIMS) [redacted] assessment, which indicated the resident was [redacted] and [redacted]. The MDS showed Resident #3 was an [redacted] assist and/or total dependence with Activities of Daily Living (ADLs); specifically transfers, bed mobility, toilet use, and personal hygiene. The MDS also revealed Resident #3 was always incontinent of bowel and bladder. A review of the "Physician's Orders (POs)" as of [redacted] did not show an order for [redacted] care nor had a diagnosis of [redacted] for Resident #3.	F 657	- The Resident #6 was discharged from the facility on 6/28/2022 and was no longer active resident during the time of the Department of Health (DOH) Complaint visit on 06/05/2023. - Resident #8: discharged from the facility on [redacted]; before facility received 2567 report. - Resident #15: discharged from the facility on [redacted] and was no longer active resident during the time of the Department of Health (DOH) Complaint visit on 06/05/2023. - Resident #3: On 6/12/23, the Care Plan (CP) was updated to include [redacted] care. In addition, the task for [redacted] care was added to Activities of Daily Living (ADL) flow sheet for all licensed nursing staff. - Resident #4: diagnosis [redacted] was added to electronic medical record (EMR); CP was updated to indicate [redacted]; Physician Order (PO) for moisture barrier "for [redacted]" was discontinued. The CP was also updated to include [redacted] care. In addition, the task for [redacted] care was added to ADL binder for all licensed nursing . Resident was reassessed for [redacted] and placed on 3-day toileting schedule; Treatment Administration Record (TAR) was updated. II. - All residents have the potential to be affected by the same deficient practice. III.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 19 The CP dated [redacted] indicated Resident #3 had a Self-Care Performance Deficit and required [redacted] assist with transfers, bed mobility, toilet use and personal hygiene. The CP also revealed Resident#3 was not care planned for [redacted] care. A review of Resident #3's "Treatment Administration Record (TAR)" dated [redacted], revealed no orders for [redacted] care. A review of Resident #3's Progress Notes (PNs), dated [redacted] to [redacted], did not address [redacted]. 2. According to the AR, Resident #4 was admitted to the facility with diagnoses that included but were not limited to: [redacted] According to the MDS, dated [redacted], Resident #4 had a BIMS score of [redacted], which indicated the resident was [redacted]. The MDS showed Resident #4 was a [redacted] assist for most ADLs; and had [redacted]. The MDS also revealed Resident #4 was always [redacted]. A review of Resident #4's POs dated [redacted], did not show a diagnosis for [redacted] or the [redacted] of the [redacted] and there was no order for [redacted]. Also on the POs was an order for "[redacted] every shift for [redacted].	F 657	- All current facility residents' CPs will be revised if there are any change in conditions, including [redacted]. All active residents will be checked for proper diagnoses, MDS coding, care plans are in place and tasks for all appropriate care, including [redacted] care placed in the ADL flow sheet. - MDS/Designee will follow policy and procedures on completing Quarterly, Annual and Significant Change MDS' if any. - Facility Educator/Designee in-serviced MDS Coordinator(s) on correct coding of assessments on 6/12/23. - Facility Educator/Designee in-serviced licensed nursing staff on facility policies and procedures on initiating base line and completing comprehensive care plans for admitted residents as well as facility policy and procedures on [redacted] Care and Interventions; in-services started on 6/12/23. - Facility Educator/Designee will continue in-services for MDS Coordinator(s) on correct coding for assessments, correct diagnosis and monitoring of completion of base line/comprehensive care plans. - Facility Educator/Designee will continue in-services for licensed nursing staff on facility policies and procedures on initiating base line and completing comprehensive care plan, for admitted residents as well as facility policy and procedures on [redacted] Care and Interventions. IV. - ADON/Designee will conduct random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20 The CP dated [redacted] and revised [redacted] indicated Resident #4 had a [redacted] related to [redacted]. The CP dated [redacted], and revised [redacted] revealed Resident#4 had [redacted] related to a [redacted]. The CP dated [redacted], and revised [redacted] revealed Resident #4 had [redacted] related to [redacted] A review of Resident 4#'s PNs, dated, [redacted] revealed the physician noted the resident had a "[redacted] for [redacted]". 3. According to the AR, Resident #6 was admitted to the facility on [redacted] with diagnoses which included but were not limited to Encounter for Surgical Aftercare Following Surgery On The Digestive System [redacted]) out onto the surface of the skin) and [redacted] According to the MDS, dated [redacted] Resident # 6 had a BIMS score of [redacted] which indicated the Resident was [redacted]. The MDS also showed Resident #6 needed [redacted] assist with Transfers and Toilet Use and with most Activities of Daily Living (ADLs). A review of Resident #6's PNs dated [redacted] at 10:46 p.m. revealed " ...new treatment order [redacted] ...awaiting pharmacy delivery ..." A review of the Order Summary Report (OSR)" [redacted] for Resident #6 revealed a POs: [redacted] Apply	F 657	audit for all [redacted] residents to ensure that all have proper diagnosis, including [redacted] MD orders, revised care plans if any significant changes, and task for all appropriate care, including [redacted] care in the ADL flow sheet; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - MDS Coordinator/Designee will conduct random audits for completion of base line/comprehensive care plans, including [redacted] residents to ensure proper coding, including for [redacted], diagnosis and MD orders; MDS Coordinator will place MDS modifications if any incorrect coding identified; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot audits on proper completion of the base line/comprehensive care plans, including ones for the residents with [redacted] diagnosis, MD orders, MDS' and tasks in the ADL flow sheets; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21 to [redacted] topically every shift for [redacted] care when changing [redacted] make a hole in it and apply around the [redacted] then apply the [redacted]. A review of Resident #6's CP initiated [redacted], revealed under "Focus": "The Resident has acute pain r/t (related/to) new colostomy surgical site." The CP also included under "Goal": "The Resident will verbalize adequate relief of [redacted] or ability to cope with incompletely relieved [redacted] through the review date." Also, under "Interventions": included, "Administer analgesia [redacted] mg (milligrams) q (every) [redacted] PRN (as needed). Give [redacted] hour before treatments or care., Anticipate Resident's need for [redacted] and respond immediately to any [redacted] ..." Further review of Resident #6's CP revealed the CP was not updated to reflect the aforementioned POs: [redacted]) Apply to [redacted] topically every shift for [redacted] when changing [redacted] make a [redacted] in it and apply around the [redacted] then [redacted], dated [redacted]. 4. According to the AR, Resident #8 was admitted to the facility with diagnoses that included but were not limited to: [redacted] with [redacted] care. According to the MDS, dated [redacted], Resident #8 had a BIMS score of [redacted] which indicated the resident had [redacted]. The MDS	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 showed Resident #8 was an [redacted] two person assist with ADLs; specifically transfers, bed mobility, toilet use, and personal hygiene. The MDS also revealed Resident #8 was always [redacted]. A review of the POs dated [redacted], had no diagnosis of [redacted] and no orders for [redacted] care. The CP dated [redacted] indicated Resident #8 had no CP for [redacted] care. A review of the TAR dated [redacted] revealed no order for [redacted] care. A review of Resident #8's PNs, dated [redacted], revealed the Resident was [redacted], [redacted] l. A PN on [redacted], revealed, "[redacted] noted in [redacted]" but did not mention [redacted] at this time. A PN dated [redacted] revealed the resident is [redacted] all or most of the time. During a tour of the facility on 6/8/23 at 9:18 a.m., the surveyor observed Resident #8 with an [redacted] that was [redacted]. The Certified Nursing Assistant (CNA) stated all incontinent residents should be changed at 6:00 a.m.during the previous shift. The CNA was unable to determine whether the resident was changed at 6:00 a.m. During a tour of the facility on 6/8/23 at 9:30 a.m.. the surveyor, in the presence of a CNA and the Director of Nursing (DON), observed Resident #4 with an [redacted] that was [redacted] with [redacted] Resident #4 stated he was last changed during the previous shift. The CNA was unable to	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23	F 657		

determine when the resident was changed during the previous shift.

During a tour of the facility on 6/8/23 at 9:45 a.m., the surveyor observed Resident #3 in a chair in the common area. The resident is [redacted] speaking and was questioned with an [redacted] The resident was able to answer all the questions asked of him/her. The resident stated he/she had gotten up this morning and changed his/her [redacted] himself/herself, by [redacted]. The resident stated he/she needed to get changed as soon as he/she goes to the bathroom because '[redacted]." Resident #3 stated the CNAs change him/her three times daily.

During an interview on 6/9/2023 at 10:38 a.m., the Director of Nursing (DON) stated "if [there is] a new medication or treatment change [for a Resident], it should be on the CP, it would be considered a change in condition, [it] would be updated on the CP."

During an interview on 6/9/2023 at 11:00 a.m., the LPN who cared for Resident #6 stated "if [a] resident has a treatment change, the Unit Manager puts the new medication or treatment on the CP."

During an interview on 6/9/23 at 2:15 p.m., the DON stated if a resident was a [redacted] that would be considered impairment of the [redacted]. During the same interview, the DON stated if a resident's care plan changed, the moment is was identified, it would be updated. If a resident was [redacted] or had a change in condition, it should be on the care plan. The DON reviewed Resident #3's care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24 plan and [redacted] care was not listed on the care plan. The DON stated, "The care plan should have been updated. The nurse is responsible for updating it." The DON reviewed Resident #4's care plan which indicated [redacted] care, even though the resident was a [redacted] The DON stated, "No, that should not have been on the care plan. The care plan should have been updated." The DON reviewed Resident #8's care plan for [redacted] care and it was not listed on the care plan. The DON stated, "It is not on the care plan. The care plan should've been updated." 5. According to the "Admission Record," Resident #15 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. A review of the annual MDS, dated [redacted] revealed that Resident #15 had [redacted] The MDS also showed that the resident needed [redacted] for bed mobility and transfers and [redacted] with personal hygiene and toilet use. The MDS also revealed that the resident was at risk for developing [redacted]. A review of the [redacted], an assessment tool used to predict the risk for [redacted] development, revealed that the facility identified Resident #15 as being [redacted].	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25 A review of the [redacted] care consult revealed that Resident #15 had an [redacted] Under "Assessment Notes: indicated that Resident #15 was "known to our service, last seen [redacted] Patient presents with an [redacted]." Under "Treatment Recommendations," indicated to "discontinue prior treatment. [redacted] aily." The [redacted] consult further revealed that the plan of care was discussed with facility staff. A review of Resident #15's physician OSR, order date range 1[redacted], revealed a physician order dated [redacted] to cleanse the [redacted] with [redacted], apply [redacted] dressing every "day shift." A review of the [redacted] TAR revealed the corresponding [redacted] physician order to cleanse the [redacted], and [redacted] dressing every "day shift," with the discontinuation date of [redacted]. The TAR included the administration time of "day" shift. A review of Resident #15's CP revealed a "Focus," initiated on [redacted] and revised on [redacted], that Resident #13 had potential for [redacted] related to [redacted]	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 26	F 657		

[redacted], no [redacted] noted." The goal, initiated on [redacted] and revised on [redacted], was for Resident #15's to have [redacted] by/through review date, revised on [redacted].
Under "Interventions" revealed the following:
1. Follow facility policies/protocols for the prevention/treatment of [redacted], revised on [redacted].
2. [redacted] to protect the [redacted] while in bed, revised on [redacted].
3. Monitor/document/report to physician as needed changes in [redacted], initiated [redacted].
4. Prompt [redacted], revised on [redacted]
5. [redacted] initiated on [redacted].
6. [redacted] consult as needed, initiated [redacted]

Further review of Resident #15's CP showed no evidence that the CP was updated for the [redacted].

During an interview on 6/9/2023 at 2:06 PM, the DON stated that the resident's CP provided a specific plan of care that fit the resident's needs. The DON added that Resident #15 had a [redacted] physician order for the [redacted] and that the new treatment order is supposed to reflect on the resident's CP. The DON reviewed Resident #15's CP, in the presence of the surveyor, and confirmed that the [redacted] was not addressed in the resident's CP. The DON added that the resident's CP should have been updated to address the [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27	F 657		

A review of the facility policy titled "Change in Condition" dated 09/2022, revealed the following under "Policy" included "It is the policy of this facility to ensure that changes (physical and non-physical) in resident's condition is communicated promptly to a licensed nursing staff to ensure the prompt evaluation and management of such changes." Under "Policy Explanation and Compliance Guidelines" revealed "...5. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted by the interdisciplinary care team as required by current Omnibus Budge Reconciliation Act of 1987 (OBRA) regulations governing resident assessments and as outlined in the MDS resident assessment instrument (RAI) Instruction Manual. 6. Care plan and medical records will be updated, as needed."

A review of the facility policy titled "Comprehensive Care Plans" dated 1/2023, revealed the following under "Policy" included"It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental psychosocial needs that are identified in the resident's comprehensive assessment." Under "Policy Explanation and Compliance Guidelines" revealed "...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28 monitor the resident's progress. Alternative interventions will be documented, as needed..."	F 657		
F 686 SS=E	N.J.A.C. 8:39-11.2 (2) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: C#: NJ#1161374, NJ#163626 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/6/2023, 6/7/2023, 6/8/2023, 6/9/2023, and 6/12/2023, it was determined that the facility failed to a.) transcribe a physician's order for the [redacted] treatment of a [redacted] in a timely manner for Resident #13 and b.) ensure that a [redacted] prevention treatment was completed in accordance with professional standards of practice for Resident #15.	F 686	I. -Resident #13 was discharged from the facility on [redacted] and no longer active resident during the time of the Department of Health (DOH) Complaint visit on [redacted] -Resident #15 was discharged from the facility on [redacted] and no longer active resident during the time of the Department of Health (DOH) Complaint visit on [redacted]	7/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 29 The deficient practices were identified for Resident #13 and #15, 2 of 2 resident reviewed for [redacted] and was evidenced by the following: 1. According to the "Admission Record," Resident #13 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] revealed that Resident #13 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. The MDS also showed that the resident needed extensive assistance with most Activities of Daily Living (ADLs). The resident required [redacted]. The MDS also revealed that the resident was [redacted] and was at risk for developing [redacted]. Review of the [redacted], an assessment tool used to predict the risk for [redacted] development, revealed that the facility identified Resident #13 as being [redacted]. Review of the Resident #13's Interdisciplinary Care Plan (CP) revealed that the facility Interdisciplinary Team identified a "Focus," initiated on [redacted], that Resident #13 had '[redacted] r/t [related to] [redacted] of the [redacted]." The goal	F 686	II. - All residents have the potential to be affected by the same deficient practice. III. - All active facility residents' ETARs checked for completion of all treatments and timely recording into ETARs. - All active facility residents' physician orders checked for proper transcriptions of the orders into the eTARs. - All physician orders sheets were audited to ensure all orders were transcribed into the TARs, including orders for [redacted] treatments; no other discrepancies identified. - All Licensed nursing staff will follow facility Policies and procedures on proper transcription of Physician orders into ETARs, on completion of all treatments as prescribed and proper recording of treatments into ETARs, including timely signing of treatments in the ETARs. - Facility Educator/Designee completed education for all Licensed Nursing staff on completing and signing off on all treatment orders in the Electronic Treatment Order Record (ETAR); in-services started on 6/12/23. - Facility Educator/Designee completed education for all licensed nursing staff on 24-hour chart checks and proper/timely orders transcription into the TARs; in-services started on 6/12/23. - Facility Educator/Designee will continue to educate all licensed nursing staff on completing and signing off on all treatment orders in the ETAR upon treatment completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 30 was for Resident #13's to be free from injury through next review date. Under "Interventions," reflected to '[redacted], and [redacted]." Review of Resident #13's [redacted] Injury report (incident report) indicated that the resident was noted with an open area on the sacrum. Under "Immediate Action Taken," revealed that [redacted] was provided and that the physician and family were informed. [The] "resident was premedicated with [redacted] prior [redacted]." Under "Predisposing Physical Factors," indicated that Resident #13 was "[redacted] Review of Resident #13's Progress Notes (PN) revealed a "late entry" "Health Status Note," with the effective date of [redacted] at 3:08 PM, that indicated the resident was noted with "an open [redacted] affected area cleansed with [redacted] applied and covered with dry dressing. Review of Resident #13's physician's "Order Summary Report" (OSR) order date range [redacted] revealed a physician order dated [redacted] for [redacted] and to apply to [redacted] every day and evening shifts for [redacted]. The OSR did not include a physician ordered that addressed Resident #13's [redacted] identified on [redacted] Review of the [redacted] Treatment	F 686	- Facility Educator/Designee will continue education for all licensed nursing staff on 24-hour chart checks and proper/timely physician orders transcription into the ETARs. IV. - ADON/Designee will conduct random audits of all active residents' ETARs to ensure they are being completed and signed timely; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - ADON/Designee will conduct random audits on the physician orders sheets to ensure all orders, including [redacted] treatment orders, are transcribed into ETARs in timely manner; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot audits on proper completion/signage of residents' ETARs to ensure completion of all prescribed treatments; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot audits on completion of 24-hour chart checks and proper transcriptions of the physician orders into ETARs; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 31	F 686		

Administration Record (TAR) revealed a [redacted] physician's order for [redacted] and to apply to [redacted] every day and evening shifts for [redacted] The TAR did not include a physician ordered that addressed Resident #13's [redacted] identified on [redacted]. The TAR further revealed no documentation that Resident #13's [redacted] treatment was completed on [redacted] and [redacted].

Review of the Resident #13's [redacted] to [redacted] "Progress Notes" (PN) revealed no documentation that Resident #13 refused any [redacted] treatments or that the resident's [redacted] treatment was completed.

During an interview on 6/6/2023 at 1:25 PM, the Registered Nurse/Unit Manager (RN/UM) who cared for Resident #13 stated the resident was [redacted], and required [redacted] assistance with ADLSs. Resident #13 was on [redacted], and that [redacted] were maintained. The RN/UM added that the resident [redacted] and was [redacted]. The RN/UM explained that with any [redacted], the nurse would notify the physician, obtain a new treatment order, and notify the family. The treatment order would then be transcribed into the electronic medical record (EMR).

During a follow-up interview on 6/7/2023 at 1:13 PM, the RN/UM stated that [redacted] treatments should be initiated in the EMR as soon as a [redacted] is identified. The [redacted] treatment would then reflect on the TAR for the nurses to continue to complete.

During an interview on 6/7/2023 at 3:19 PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 32	F 686		

Director of Nursing (DON) explained the nursing practice when a new [redacted] is identified. The DON stated the nurse [redacted] complete an incident report and notify the physician and family. The DON added that a [redacted] treatment would be obtained from the physician and transcribed into the EMR. The treatment order would be initiated immediately and that it would reflect on the TAR for the nurses to complete. When questioned about the timely initiation of Resident #13's wound treatment for the [redacted] noted on [redacted], the DON stated he would have to look into it and would follow up with the surveyor.

During a follow-up interview on 6/8/2023 at 11:59 AM, the DON stated that he looked into the timely initiation of Resident 13's [redacted] treatment and confirmed the surveyor's findings. The DON stated that Resident #13's [redacted] treatment was initiated on [redacted] and not on [redacted] when the [redacted] was identified. The DON stated the nurse was interviewed and stated that she forgot to transcribe the physician order into the EMR. The nurse stated she worked a double that day and had gotten caught up with other things. The DON further stated the nurse should have transcribed the physician order immediately after receiving it from the physician. The DON added that it was important to transcribe physician orders timely to make sure that the treatments are being completed as ordered.

2. According to the "Admission Record," Resident #15 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 33 Review of the annual MDS, dated [redacted], revealed that Resident #15 had [redacted]. The MDS also showed that the resident needed [redacted] for bed mobility and transfers and [redacted] with personal hygiene and toilet use. The MDS also revealed that the resident was at risk for developing [redacted]. Review of the [redacted] revealed that the facility identified Resident #15 as being [redacted] for developing a [redacted]. Review of Resident #15's CP revealed a "Focus," initiated on [redacted], that Resident #13 had potential for [redacted] related to [redacted] and [redacted]. The goal, initiated on [redacted], was for Resident #15's to have [redacted], or [redacted] by/through review date. Under "Interventions" reflected to "follow facility policies/protocols for the prevention/treatment of [redacted]." Review of Resident #15's physician OSR order date range [redacted], revealed a physician order dated [redacted] "[redacted]) and to apply to [redacted] topically at [redacted]. Review of the [redacted] TAR revealed the corresponding [redacted] physician order for [redacted] to be applied to [redacted] topically at bedtime for protection, with the discontinuation date of [redacted]. The TAR included the administration time of 9:00 PM. The TAR further revealed no documentation that	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 34 the physician ordered [redacted] was applied to Resident #15's [redacted] on the following dates: 1/12/2023, 1/13/2023, 1/14/2023, 1/15/2023, 1/16/2023, 1/17/2023, 1/18/2023, and 1/19/2023. Review of the Resident #15's [redacted] to [redacted] PN revealed no documentation that Resident #15 refused any [redacted] treatments or that [redacted] was applied to Resident #15's [redacted] as ordered. During an interview on 6/6/2023 at 1:25 PM, RN/UM stated that nurses sign the medications and treatments as administration in the EMR. The RN/UM further stated that there should not be any blanks on the Medication Administration Record (MAR) and TAR. The RN/UM added that the nurse would document the reason for not completing a physician order in the resident's PN. During a follow-up interview on 6/8/2023 at 3:06 PM, the RN/UM stated that she could not recall Resident #15 and that the resident was gone by the time she started working on the unit. During an interview on 6/12/2023 at 11:01 AM, the DON stated "[redacted] was used as a preventative measure to prevent a [redacted] from [redacted] for residents at risk for developing [redacted]. The DON added that [redacted]" orders were documented on the TAR and the nurses were responsible for administering the treatment as ordered by the physician. When questioned about the completion of Resident #15's [redacted] treatment on the aforementioned dates, the DON stated he would look into it and follow up with the surveyor. During a follow-up interview on 6/12/2023 at	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 35	F 686		

12:25 PM, the DON confirmed that the nurses did not document that [redacted] was applied to Resident #15's ankle on the aforementioned dates. The DON stated that treatment orders are transcribed into the EMR and are reflected on the TAR for the nurses to sign. The DON further stated the nurses should sign the TAR when they completed the treatment. The DON added that skin prep should be administered per the physician order and that if the treatment was not signed out, then it was not done. The DON further stated that nurses should complete the resident's treatment per the physician order.

During an interview on 6/12/2023 at 1:26 PM, the Administrator stated physician orders were to be transcribed onto the EMR and completed per the physician order. The Administrator further stated that she expected nurses to document the completion of treatments immediately and that the nurses had laptops on their medication cart to document as needed.

Review of the facility's undated "[redacted] Prevention & Management Policy," indicated under "Procedure" that "7. The Licensed Nurse is responsible to implement the [redacted] TREATMENT PROTOCOL (See [redacted] Treatment Policy), unless otherwise ordered by the attending physician. All treatments except for [redacted] for [redacted] require a physician's order."

Review of the facility's "Physician Orders" policy, "rev" on 2/2023, indicated that the nurse receiving the order must ... "enter the order into the medical record" and to "follow through with orders by making appropriate contact or notification."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 36	F 686		

Review of the facility's "Medication Administration-Policy and General Guidelines," revised on 2/2023, indicated under that "medications are administered, as prescribed, in accordance with good nursing principles and practices, and only by persons legally authorized to do so ... Medications are administered in accordance with State and Federal regulations." The "Purpose" is "to ensure the safe, accurate, and timely administration of medications." Under "Procedure," indicated that topical medications used in treatments and dosage schedules should be listed in the TAR.

Review of the facility's undated "Skin Check Policy," included under "Procedure" that "6. Where new open areas are present ... The Licensed Nurse will also inform the attending physician, family/responsible party, and initiate treatment according to the [redacted] Treatment Protocol Policy."

Review of the facility's "[redacted] Treatment Management" policy, "rev" 9/2022, revealed under "Policy" "To promote wound healing of various types of wounds, it is the policy of this facility to provide evidenced-based treatments in accordance with current standards of practice and physician orders." Under "Policy Explanation and Compliance Guidelines," indicated that "1. [redacted] treatments will be provided in accordance with physician orders, including the cleansing method, type of [redacted], and frequency of [redacted] ... 6. Treatments will be documented on the Treatment Administration Record."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 37	F 686		
F 692 SS=G	NJAC 8:39-27.1(a) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: C#: NJ#159535, NJ#163626 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/8/2023 and 6/9/2023, it was determined that the facility failed to a.) identify and address a significant unplanned [redacted] of 7.5 % in one month, b.) implement and monitor weekly weights, and c.)	F 692	I. - Resident #13: discharged from the facility on [redacted] and was no longer active resident during the time of the Department of Health (DOH) Complaint visit on 06/05/2023. - Resident #15 was discharged from the facility on [redacted] and was no longer active residents during the time of the	6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 38 comprehensively assess the resident after a significant weight change to prevent further [redacted] for a resident with a history of weight loss, in a timely manner. The facility also failed to follow its policy titled "Weight Management Protocol." This deficient practice was identified for 1 of 2 residents reviewed (Resident #15) for [redacted] and was evidenced by the following: Reference: The Academy of Nutrition and Deititians, "Position of the Academy of Nutrition and Dietitianss: Individualized Nutrition Approaches for Older Adults: Long-Term Care, Post-Acute Care, and Other Settings", dated April 2018. Position Statement "It is the position of the Academy of Nutrition and Dietitians that the quality of life and nutritional status of older adults in long-term care, post-acute care, and other settings can be enhanced by individualized nutrition approaches. The Academy advocates that as part of the interprofessional team, registered Dietitian nutritionist assess, evaluate, and recommend appropriate nutrition interventions according to each individual's medical condition, desires, and rights to make health care choices. Nutrition and dietetic technicians, registered assist registered Dietitian nutritionists in the implementation of individualized nutrition care." Review of the facility's "Weight Management Protocol" policy, "Rev 4/2014," reflected under "Guidelines" that "monthly weights must be done the first week of each month completed by the 10th of the month and document in the medical record." The policy indicated that "the threshold for significant unplanned and undesired weight	F 692	Department of Health (DOH) Complaint visit on 06/05/2023. II. - All residents have the potential to be affected by the same deficient practice. III. - RD/Designee completed weekly random audits for weight changes if any; Interdisciplinary Care Performance (IDCP)Team will meet weekly to identify root-cause for all weight changes if any. All results will be recorded into the Weight Change tool and addressed accordingly as per facility Weight Policy and Procedures. - ADON/Designee will ensure that all monthly weights obtained by 10th of each month; all discrepancies, if any, will be re-weighted within 24 hours; all weight change notifications will be completed and documented in Electronic Medical Record (EMR); meal intakes and weekly weight interventions are in place for all residents with [redacted]; care plans are in place. - Facility Educator/Designee in-serviced facility Licensed Dietician on facility Weight Policy and Procedures on 6/12/23. - Facility Educator/Designee initiated in-service on facility Weight Policy and Procedures for all licensed nursing staff to ensure timely completion of the admission weights for newly admitted residents, monthly weights and weekly/daily weights if prescribed; in-service started on 6/12/23. - RD/Designee will continue monthly audits for all residents with weight	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 39 loss/gain will be based on the following criteria ... a. 1 month - 5% weight loss is significant; greater than 5% is severe. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. c. 6 months - 10% weight loss is significant; greater than 10% is severe." "A re-weigh of residents within 24 hours, experiencing a significant unplanned and undesired weight loss/gain, should be witnessed and initialed by a licensed care partner for verification." The policy indicated the Dietician would be notified in the event of a verified weight loss or gain. The policy revealed that "a. Meal intake will be monitored for each meal by the Nursing department, b. weight will be done x 4 weeks, or more frequently as needed, or until stable, c. The care plan (CP) will be updated based upon recommendation of the Interdisciplinary Care Partner team (IDCP) to reflect the weight loss/gain problem, the appropriate goal, and interventions. d. Interdisciplinary Notes will focus on weight problem, monitoring, interventions, and resident response; such as increased intake or weight gain/loss as desired. e. Resident's medication and lab values will be reviewed for possible cause of weight loss/gain." According to the "Admission Record," Resident #15 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]. Review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that Resident #13 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the	F 692	changes to address all significant weight changes to IDCP team; RD will document all weight changes in EMR, interventions will be recorded in care plan; MD will be notified if significant changes. - Facility Educator/Designee will continue in-services for nursing staff on facility Weight policies and procedures to ensure timely weight obtaining for all residents. IV. - RD/Designee will continue to conduct audits for all residents that triggered for weight change as per Weight Exception Report to ensure that all residents with significant weight change are followed and all proper interventions are in place; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot audits on residents with significant weight change to ensure that they are followed and all proper interventions are in place ; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 40	F 692		

resident had [redacted]. The MDS also showed that the resident needed extensive [redacted] with all Activities of Daily Living (ADLs). Further review of the MDS showed that the resident had [redacted] of 5% or more in the last month or a [redacted] of 10% or more in 6 months, and that resident was not on a prescribed [redacted] regimen.

Review of Resident #15's Nutrition Note, (NN) written by the Registered Dietician (RD), on [redacted] at 12:48 PM, indicated that the resident was seen for a quarterly review and triggered for significant [redacted] lbs. or [redacted] % in six months. The NN revealed that the weight loss was unfavorable related to the resident having a BMI (body mass index) of [redacted], indicating that the resident was [redacted], along with [redacted]. The RD documented that the were no new recommendations at this time and to continue with current plan of care. "RD to follow and make changes as needed."

Review of the NN, written by the RD, on [redacted] at 12:54 PM, documented additional supplements of [redacted] for breakfast and [redacted] at lunch.

Review of Resident #15's physician's "Order Summary Report (OSR)," for active orders as of [redacted], revealed the following physician orders:
1. A physician order dated [redacted] and to provide [redacted] three times a day for supplementation.
2. A physician order dated [redacted] for [redacted] in the morning with breakfast
3. A physician order dated [redacted] for [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 41 [redacted] in the afternoon with lunch. Review of the Resident #13's [redacted] Medication Administration Record (MAR) revealed the corresponding [redacted] physician order for [redacted] times a day for supplementation, with the discontinue date of [redacted]. The MAR included the administration times of 10:00 AM, 2:00 PM, and 7:00 PM. The MAR further revealed the corresponding [redacted] physician order for [redacted] in the morning with breakfast, with the discontinue date of [redacted]. The MAR included the administration time of 9:00 AM. The MAR also revealed the corresponding [redacted] physician order for [redacted] in the afternoon with lunch, with the discontinue date of [redacted]. The MAR included the administration time of 12:00 PM. Review of Resident #15's Care Plan (CP) revealed a "Focus," initiated on [redacted] that Resident #13 had a [redacted] related to the diagnoses that included but were not limited to [redacted] The goal, initiated on [redacted], was for Resident #15's to not experience a significant, [redacted] change through the review date. Under "Interventions," reflected to assist with meals, honor dietary preferences as able, provide and serve diet as ordered. Provide supplements as ordered: [redacted] at breakfast and [redacted] at lunch, healthy shakes with meals, and family to provide [redacted] and [redacted] supplement as needed." Review of the facility provided, "Weights and	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 42 Vitals" (weights), date range 2/1/2022 to 10/31/2022, revealed the following: 3/3/2022 a weight of [redacted] pounds. (lbs.); [redacted] change [comparison weight [redacted] lbs., -[redacted] lbs.] 5/13/2022 a weight of [redacted] lbs; [redacted] % change [comparison weight [redacted] lbs., [redacted] lbs.]; [redacted] % change [comparison weight 3/3/2022, [redacted] lbs., [redacted] and -[redacted] change [comparison weight [redacted], [redacted] lbs., [redacted] lbs.] There were no additional weights documented following the [redacted] significant [redacted]. The weights further reveal no documentation that Resident #15's weight was obtained for the month of [redacted]. Review of the resident's Progress Notes (PN) from [redacted] through [redacted] revealed no documentation that Resident #15's physician was notified [redacted] significant [redacted]. The PN did not contain any additional notes from the RD and any assessment to determine the causal factor of Resident #15's [redacted] significant [redacted] Review of the resident's "late entry" Physician Progress Note, with the effective date [redacted] at 4:43 PM, revealed no documentation about Resident #15's [redacted] significant [redacted]. Further review of Resident #15's weights revealed a [redacted] weight of [redacted] lbs.; [redacted] change [comparison weight [redacted], [redacted] lbs., [redacted] lbs.]	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 43 Resident #15 had lost an additional [redacted] lbs. from [redacted]. Review of Resident #15's NN, written by the RD, on [redacted] at 2:36 PM, indicated that the resident was seen for a quarterly review and that there was no changed with the resident's [redacted] status. The NN revealed that the resident triggered for significant [redacted] of [redacted] lbs. or [redacted] % [redacted] months and [redacted] in [redacted] months. The NN revealed that the [redacted] was unfavorable related to the resident having a BMI of [redacted] which indicated the resident was [redacted], along with [redacted] and [redacted]. The NN further revealed that Resident #15's [redacted] laboratory results revealed an [redacted]. [The normal level is [redacted] level may indicate [redacted] The RD recommended to assist the resident will meals and to continue all other interventions. "RD to follow and make changes as needed." Resident #15's BMI had decrease by [redacted] from the previous BMI of [redacted] that was documented in the [redacted] NN, written by the RD. Review of Resident #15's physician's OSR, for active orders as of [redacted], revealed a [redacted] physician order for [redacted] and to administer [redacted] millimeters (ml) one time a day for [redacted] Review of the Resident #13's [redacted] MAR revealed the corresponding [redacted] physician order, with the discontinuation of [redacted], for [redacted]. The MAR included the administration	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 44	F 692		

time of 9:00 AM.

During an interview on 6/8/2023 at 2:55 PM, the Licensed Practical Nurse (LPN) #1 stated that monthly weights were obtained between the first and the [redacted] of the month and that the nurses and Unit Manager (UM) were responsible for making sure the were obtained. The LPN added that the nurses and the Certified Nurse Assistants (CNA) could obtain a residents' weights and that the nursing staff were responsible for entering the weight into the electronic medical record (EMR.) The weights would then be reviewed by the UM and RD.

During an interview on 6/8/2023 at 3:06 PM, the Registered Nurse/Unit Manager (RN/UM) stated that monthly weights were obtained by the nursing staff and inputted into the EMR for the RD to review. Th RD would review the weights and inform the nursing staff of any [redacted] . The RD comes to the weight meeting with a spreadsheet of all the [redacted] for the interdisciplinary team (team) to review. The team included the RD, Director of Nursing (DON), Unit Manager and sometimes the Licensed Nursing Home Administrator (LNHA). They would discuss the plan of care for the residents with significant weight loss, the physician would be notified, meal consumption would be monitored, and a referral to Speech Therapy for evaluation may be initiated.

During an interview on 6/8/2023 at 3:20 PM, the RD stated her responsibilities included the monitoring residents' weights for [redacted], nutritional evaluation of newly admitted residents, and completing the quarterly and annual nutrition reviews. The RD added that weights were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 45	F 692		

obtained by the 10th of each month and that she tracked to see which resident triggered for a significant weight loss in the past one month, three months, and six months. A 5 % or more weight loss in one month was considered significant and the resident would need to be reassessed. The resident's preferences and meal consumption would be reviewed and supplements and/or referral to speech therapy wound be initiated, if necessary. The RD added that any interventions would be documented in the resident's PN, and that nursing would notify the resident's physician and family of the [redacted]. The UM would document the notification in the resident's PN. The RD stated Resident #15 was [redacted] required assistance with [redacted], was on supplements, and that their family also provide additional supplements. When questioned about Resident #15's significant [redacted], the RD stated she would have to look into it and would follow up with the surveyor.

During a follow-up interview on 6/9/2023 at 9:47 AM, the RD stated that Resident #15 never had a significant weight loss. The RD continued that she completed a NN noted on [redacted] and that the resident had triggered for a significant weight loss for the prior six months. The RD further stated that she recommended [redacted] three times a day, one scoop of [redacted]" and that the resident was eating 50 % to 100% of meals at that time. The RD added that the recommendations in place were appropriate and that they met Resident #15's needs. The surveyor questioned Resident #15's [redacted] from April 2022 to May 2022. The RD reviewed the Resident #15's weights in the EMR and calculated the [redacted] percentage for aforementioned months, in the presence of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 46	F 692		

surveyor. The RD stated that Resident #15 triggered for a significant [redacted] lbs. which was 7.5 % [redacted] in one month. The RD added that there was nothing in the resident's medical record that indicated that the resident was re-weighed. The RD further stated the next NN documented in the EMR was on [redacted] and that she recommended [redacted] for [redacted]. When question if the physician was notified of the Resident #15's significant [redacted], the RD stated she was not sure if the physician was notified, and that the UM was responsible for notifying the resident's physician. The surveyor question if Resident #15's [redacted] was assessed in [redacted], the RD stated there was no weight obtained for the resident for the month of [redacted]. The RD added that there were difficulties with staff obtaining the residents' weights back then and that they were not being obtained in a timely manner. The RD continued that Resident #15's weight had stabilized in [redacted] and that the new weight had become his/her baseline. When questioned about the resident's [redacted] weight, the RD stated the resident had [redacted] from [redacted] to [redacted]. The RD explained the facility process when a significant [redacted] is identified. The resident would be re-weighed, weekly weights would be initiated, meals would be monitored, the resident would be reassessed for new interventions, and the CP would be updated by the RD. The RD added that everything would be documented in the EMR. The RD stated that the [redacted] weight meeting was conducted on [redacted] and at the time, Resident #15's weight was still pending. The RD further stated that the [redacted] weight meeting was conducted on [redacted] and that Resident #15 was not discussed during that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 47	F 692		

meeting because the weight had not been obtained. The RD added that normally she would follow up with nursing for the weight and that in a week she would check again with nursing if the resident's weight had not been obtained. The RD added that Resident #15 had came back on the weight meeting list for the month of [redacted] and that the resident's significant [redacted] was addressed at that time. The RD stated that Resident #15 was maintaining a weight of [redacted] lbs. to [redacted] lbs., and that the interventions in placed met their need. The resident was being assisted with meals, supplements were in place, and was eating [redacted] of meals. The RD explained that the UM was responsible for the documenting and monitoring the residents' weight in the EMR. She would then review the weights, generate a report with all the resident's weight by unit, and compare the weights by one month, three months, and six months. The RD stated that back then, the weights were imputed late and that she had additional responsibilities. The RD further stated that she did not know why the resident's weight was not obtained or assessed for the month of [redacted].

Review of the 5/13/2022 "Weight Meeting" sheets revealed that Resident #15's May 2022 weight was pending.

Review of the 7/1/2023 "Weight Meeting" sheets did not include documentation for Resident #15.

Review of the 7/29/2023 "Weight Meeting" sheets revealed that Resident #15 had a [redacted] lbs. or [redacted] times 3 months and a [redacted] lbs. or [redacted] % weight loss in six months. Under the "Comments/Interventions," included the following interventions: unfavorable [redacted], regular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 48	F 692		

[redacted] daily, health shakes three times a day, SF ALP once daily, and assist with meals.

During an interview on 6/9/2023 at 10:22 AM, the DON stated that residents' weights were monitored monthly to monitor for any weight loss or gain. If a significant [redacted] was identified, the resident would need to be re-evaluated. The UM and RD are responsible for monitoring residents' weights in order to identify any significant weight loss or gain. The DON added that the EMR triggers a significant [redacted] once inputted and that they try to get on top of it as soon as possible. The DON explained that the resident would be reweighted, reassessed, food preferences and medications would be reviewed, speech and or psychiatry evaluations would be initiated, if needed. The resident physician and family would be notified by either the UM or RD and the notification would be documented in the resident's EMR. The RD generates a report monthly for residents with either weight loss or gain and those residents are discussed during the monthly weight meeting. The team discusses new interventions and would monitor the residents with a significant [redacted] closely. Inteventions wound include a calorie count to assess the resident's meal consumption. The RD would document any new interventions and notify the physician and family. The DON stated that any missing weight noted during the monthly weight meeting should be obtained right away and that it was important to obtain the weight because the team would not be able to identify if a significant [redacted] had occurred. The DON continued that they would come together as a team and would take a holistic approach in order to come up with proper interventions for any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 49	F 692		

resident with significant [redacted]. The resident's family and physician would also be notified because they would have to be on board with everything. The DON added that a physician order for weekly weights would be obtained and documented on the resident's Treatment Administration Record.

Review of Resident #15 May 2022, June 2022, and July 2022 revealed no physician order for weekly weights.

During interview on 6/9/2023 at 1:00 PM, the LPN #2 stated that she used to be the UM for Resident #15's unit. LPN #2 further stated that resident's weights were reviewed monthly and the team would discuss the residents that with a weight loss or gain. LPN #2 added that the CNAs would obtain the weights, the nurses would document the weights in the EMR, and the Charge Nurse or UM would review them. The residents identified with a significant weight loss or gain would be discussed at the next weight meeting. The team would hold off discussing the residents with missing weights and they would try to obtain the weight as soon as possible. The weight would be obtained and given to the RD, who would then assess the resident and inform nursing of any new interventions. When questioned about Resident #15, the LPN stated that she could not recall the resident. The LPN review Resident #15's EMR, in the presence of the surveyor, and stated that she now remembered the resident. The LPN stated that Resident #15 was pretty good and required a lot of encouragement with meals. The LPN added that the resident had a poor appetite, needed to be assisted with meals, and was able to verbalize when he/she had enough food.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 50	F 692		

During a follow-up interview on 6/9/2023 at 2:06 PM, the DON stated that he had no further information about Resident #15 significant weight loss from April 2022 to May 2022. The DON added that a significant [redacted] would be considered as a "change in condition" and that it should be reported to the resident's physician and documented in the EMR. The DON further stated the physician's documentation would address the resident's weight loss and the intervention that were put in place.

No further information was provided by the facility.

Review of the facility's "Change in Condition" policy, "rev 10/2019," revealed under "Policy" that the facility would ensure that changes in the resident's condition is communicated promptly to the licensed nursing staff to ensure prompt evaluation and management of such changes. "Changes in condition will be communicated to the Attending Physician, resident and/or resident representative .... Care plan and medical records will be updated, as needed."

Review of the undated "Title: Registered Dietician" revealed Under "Job Function:" included: " ... Completes comprehensive nutrition assessments ... in accordance with federal and state regulatory guidance. Completes comprehensive assessments in accordance with current standards of practice. Consults with resident, family, or interdisciplinary team as needed regarding the plan of care for residents."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 51	F 692		
F 697 SS=G	NJAC 8:39-17.1(c) Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: C#: NJ#161374 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, 6/7/2023, 6/8/2023, and 6/9/2023, it was determined that the facility failed to consistently follow resident's care plans, evaluate a resident's pain and ensure that pain medications were administered according to the physician's orders (PO's) for a resident who was experiencing [redacted]. The facility also failed to follow its policies titled "[redacted] Management" and "Medication Administration." This deficient practice was identified for Resident #13, 1 of 1 resident reviewed for [redacted] management, and was evidenced by the following: Review of the facility's [redacted] Management" policy, revised on 9/2022, indicated, "The facility must ensure that [redacted] management is provided to residents who require such services, consistent with professional standard or practice, the	F 697	I. -Resident #13 was discharged from the facility on [redacted] and no longer active resident during the time of the Department of Health (DOH) Complaint visit on 06/05/23. - ADON/Designee completed full audit of all current Narcotic Declining Sheets for all current facility residents immediately on 6/7/23; results recorded in the Narcotic Declining Audit form, no other discrepancies identified. II. - All facility Residents having the potential to be affected by the same deficient practice. III. - DON/Designee audited all Narcotic Declining Sheets for all facility Residents on Controlled Schedule II medications for proper administration/recording on 6/7/23; no other discrepancies identified. All	6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 52	F 697		

comprehensive person-centered care plan and the resident's goals and preferences." Under "Treatment" revealed " ...5. "Pharmacological interventions should follow a systemic approach."

Review of the facility's "Medication Administration-Policy and General Guidelines," revised on 2/2023, indicated under that "medications are administered, as prescribed, in accordance with good nursing principles and practices, and only by persons legally authorized to do so ... Medications are administered in accordance with State and Federal regulations." The "Purpose" is "to ensure the safe, accurate, and timely administration of medications." Under "Procedure," indicated the Medication Administration Record (MAR) "is electronically initialed by the person administering a medication immediately after administration of the medication. All routine Controlled Schedule II, III, IV, V medications are documented in the electronic MAR at the time of administration. All doses of Controlled Schedule II and PRN [as needed] III, IV, V medications are signed out in both the Controlled Substance Book and the electronic MAR at the time of administration."

According to the "Admission Record," Resident #13 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted] secondary malignant neoplasm of bone, and prostate.

Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that Resident #13 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. The

results recorded in the Daily Narcotic Declining Audit form.
- All licensed nursing staff will follow facility Policy and Procedures on Medication Administration, including Controlled Schedule II medications and proper completion of the Narcotic Declining sheet upon Controlled Schedule II medication administration.
- All licensed nursing staff were re-trained on facility Policy and Procedures on Medication Administration, including administration of all routine Controlled Schedule II medications. In addition, all licensed nursing staff were re-in-serviced on proper use of the Narcotic Declining Sheet, including how to follow the facility declining sheet completion; all trainings/in-services started on 6/7/23.
- Facility Educator/Designee will continue to in-service all licensed nursing staff on proper routine Controlled Schedule II medications administration and completion of the Narcotic Declining Sheet.
- Facility Educator will in-service all nursing licensed staff on following facility's policy and procedures on Medication Administration, including Controlled Schedule II medications and completion of the Narcotic Declining sheet by 6/12/23 and monthly as needed.

IV.
- ADON/Designee will conduct daily checks/audits of all Narcotic Declining sheets for proper administration/recording of all routine Controlled Schedule II medications to ensure proper recording as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 53 MDS also showed that the resident needed extensive assistance with most Activities of Daily Living (ADLs) and received a scheduled and as-needed [redacted] medication regimen. Further review of the MDS also showed that a [redacted] assessment should be completed for the presence of [redacted], and the resident has [redacted] occasionally with a [redacted] intensity descriptor rating of moderate. A review of Resident #13's Care Plan (CP) revealed a "Focus," initiated on [redacted] that Resident #13 had [redacted] process. The goal was for Resident #13's to not have an interruption in normal activities due to [redacted] Under "Interventions," reflected to anticipate the need for [redacted], respond immediately to any complaint of [redacted] and evaluate the effectiveness of [redacted] interventions as needed. Review for compliance, alleviating of symptoms, dosing schedules, and resident satisfaction with results, impact on functional ability, and impact on cognition. Identify and record previous [redacted] history and management of that [redacted] and impact on function. Identify and record previous [redacted] history and management of that [redacted] and impact on function. Identify previous responses to [redacted], including [redacted], side effects, and impact on function. Identify, record, and treat the resident's existing conditions, which may increase [redacted] and or discomfort and [redacted]. Monitor/document for probable cause of each [redacted] episode. Remove/limit causes where possible. Review of Resident #13's physician's "Order Summary Report" (OSR) order date range [redacted], revealed a physician order	F 697	per facility policy and procedures. All audit results will be recorded in the Narcotic Declining Audit Form; audits will be conducted daily X 2 weeks, weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will conduct spot checks/audits on proper completion of the Narcotic Declining sheet; all results will be recorded in the Narcotic Declining Audit form; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits will be presented to the monthly QAPI meetings 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 54 dated [redacted] for [redacted] (a Schedule II narcotic used for relief of [redacted]) ([redacted] milligrams/milliliters (unit of measurement) (mg/ml) and to administer [redacted] ml [for a total dose of [redacted] mg] every [redacted] hours for [redacted]. Review of the Resident #13's [redacted] MAR revealed the corresponding [redacted] physician order for [redacted] mg/ml and to administer [redacted] ml every [redacted] hours for [redacted], with a discontinued date of [redacted] The MAR included the administration times of 12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. The [redacted] MAR revealed that Resident #13 had a [redacted] level of [redacted] out of [redacted] on [redacted] at 8:00 AM and that [redacted] had been administered. Review of Resident #13's "Individual Patient Controlled Substance Administration Record" (declining sheet) (a narcotic medication sheet used to document the date and time the medication was removed, the nurse's signature and a declining count of the medication) for [redacted] did not include documentation that the medication was removed for administration for the [redacted] 8:00 AM dose. Further review of Resident #13's [redacted] MAR revealed that Resident #13's [redacted] level was a [redacted] out of 10 at 12:00 PM and had increased to a "[redacted] out of [redacted] at 4:00 PM on [redacted] Review of Resident #13's Progress Notes (PN) revealed no additional documentation about the resident's [redacted] administration.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 55	F 697		

Review of Resident #13's "Progress Notes" (PN) revealed a Medication Administration Note" (MAN), with the effective date of [redacted]3 at 7:24 PM, that indicated Resident #13 had refused vital signs due to[redacted]

Review of Resident #13's OSR revealed a physician order, dated [redacted], for [redacted] mg/ml and to administer [redacted] ml every [redacted] hours for [redacted]

Review of the Resident #13' [redacted] MAR revealed the corresponding [redacted] physician order for [redacted] mg/ml and to administer [redacted] ml every [redacted] hours for [redacted], with a discontinued date of [redacted]. The MAR included the administration times of 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM.

The [redacted] MAR revealed no documentation that Resident #13's [redacted] was assessed or that he/she received the physician ordered [redacted] doses on [redacted] at 6:00 PM and 10:00 PM.

Review of Resident #13's declining sheet for [redacted] did not include documentation that the medication was removed for administration for the [redacted] 6:00 PM and 10:00 PM doses.

Further review of Resident #13's [redacted] MAR revealed that Resident #13 had a [redacted] of [redacted] out of [redacted] on [redacted] at 8:00 PM, which was the next administration time for [redacted] after the missed 6:00 PM dose. The MAR further revealed that the resident's [redacted] had increased to a [redacted] out of [redacted] on [redacted] at 12:00 AM, which was the next administration time for [redacted] after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 56 the missed 10:00 PM dose. Review of Resident #13's PN revealed no additional documentation about the resident's [redacted] administration. The [redacted] MAR revealed that Resident #13 had the following [redacted] levels and that [redacted] had been administered: 1. A [redacted] of '[redacted] out of [redacted] on 2/5/2023 at 8:00 AM. 2. A [redacted] of '[redacted]" out of [redacted] on 2/5/2023 at 2:00 PM. 3. A [redacted] of [redacted] out of [redacted] on 2/9/2023 at 2:00 PM. Review of Resident #13's declining sheet for [redacted] did not include documentation that the medication was removed for the administration of the 2/5/2023 8:00 AM, 2:00 PM, and the 2/9/2023 2:00 PM doses. Further review of Resident #13's [redacted] MAR revealed that, on 2/5/2023, Resident #13's [redacted] remained at an [redacted] out of [redacted]. On 2/9/2023, the resident's [redacted] had increased to an '[redacted] out of [redacted] at 4:00 PM, which was the next administration time for Morphine. Review of Resident #13's PN revealed no additional documentation about the resident's [redacted] and [redacted] administration. Review of Resident #13's Physician Progress Note (PPN), with the effective date of [redacted] at 9:58 PM, revealed that the [redacted] registered nurse reported the resident as somnolent but still noted with [redacted]. The PPN further revealed that the physician would increase the	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 57 [redacted] dose to[redacted] mg every [redacted] hours. Review of Resident #13's PPN, with the effective date of[redacted] at 11:23 AM, indicated that nursing had initiated [redacted] mg every [redacted] hours that morning, and the resident was [redacted], with no [redacted] noted and was[redacted]. Review of Resident #13's OSR revealed a physician order, dated [redacted] for [redacted] mg/ml and to administer [redacted] ml [for a total dose of [redacted] mg] every [redacted] hours for [redacted]. Review of the Resident #13' 2/2023 MAR revealed the corresponding 2/12/2023 physician order for [redacted] mg/ml and to administer [redacted] ml every [redacted] hours for [redacted], with a discontinued date of [redacted]. The MAR included the administration times of 12:00 AM, 2:00 AM, 4:00 AM, 6:00 AM, 8:00 AM, 10:00 AM, 12:00 PM, 2:00 PM, 4:00 PM, 6:00 PM, 8:00 PM, and 10:00 PM. The 2/2023 MAR revealed no documentation that Resident #13's [redacted]l was assessed or that he/she received the physician ordered [redacted] dose on 2/12/2023 at 2:00 PM. Review of Resident #13's declining sheet for [redacted] did not include documentation that the medication was removed for administration for the 2/12/2023 2:00 PM dose. Further review of Resident #13's [redacted] MAR revealed the resident's [redacted] was [redacted] out of [redacted] on 2/12/2023 at 12:00 PM. Resident #13's [redacted] had increased to an '[redacted] at the 4:00 PM [redacted] assessment, which was the next	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 58 administration time for [redacted] after the missed 2:00 PM dose. Review of Resident #13's PN revealed no additional documentation about the resident's 2/12/2023 [redacted] administration. The [redacted] MAR revealed that Resident #13 had the following pain levels and that Morphine had been administered: 1. A [redacted] of '[redacted]" out of [redacted] on 2/12/2023 at 6:00 PM. 2. A [redacted] of [redacted] out of [redacted] on 2/13/2023 at 6:00 AM. 3. A [redacted] of [redacted] out of [redacted] on 2/14/2023 at 12:00 AM. 4. A [redacted] of [redacted] out of [redacted] on 2/14/2023 at 2:00 AM. Review of Resident #13's declining sheet for [redacted] did not include documentation that the medication was removed for the administration of the 2/12/2023 at 6:00 PM, 2/13/2023 at 6:00 AM, 2/14/2023 at 12:00 AM, and 2/14/2023 at 2:00 AM doses. Further review of Resident #13's 2/2023 MAR revealed the following: 1. The resident's [redacted] had increased to a '[redacted] out of [redacted] on 2/12/2023 at 8:00 PM. 2. A [redacted] of '[redacted]" out of [redacted] on 2/13/2023 at 8:00 AM. 3. The resident's [redacted] had increased to a [redacted] out of [redacted] on 2/14/2023 at 2:00 AM. 4. The resident's [redacted] remained at a [redacted] out of [redacted] on 2/14/2023 at 4:00 AM. Review of Resident #13's PN revealed no additional documentation about the resident's	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 59 2/12/2023, 2/13/2023, and 2/14/2023 [redacted] administration. During an interview on 6/6/2023 at 1:25 PM, the Registered Nurse/Unit Manager (RN/UM) who cared for Resident #13 stated the resident was [redacted] and required [redacted] with ADLSs. The RN/UM stated that the resident experienced a lot of [redacted], had standing physician orders for [redacted] medication, and was medicated as requested. Resident #13 was on [redacted] care, and that [redacted] were maintained. The RN/UM added that the resident had [redacted] was [redacted], and that she felt bad because the resident was in a lot [redacted]. The RN/UM stated there were family dynamics involved, the physician was in constant communication with both family members, and that care was administered per the physician's assessment and orders. During a follow-up interview on 6/7/2023 at 1:13 PM, the RN/UM explained the nursing practice when administering [redacted]. The RN/UM stated the nurse measures out the physician-ordered amount in a [redacted], record the date, time, amount removed, and their signature on the declining sheet. The nurse would administer the medication to the resident, and then returns to the medication cart to sign the medication as administered on the MAR. The RN/UM added that the MAR and the declining sheet should match and that [redacted] was always available because [redacted] are kept in backup. The RN/UM stated that standing [redacted] medications should be administered as ordered, and there should not be any blanks on the MAR. The RN/UM added that blanks on the MAR indicated	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 60	F 697		

that the nurse forgot to sign the MAR. When questioned about Resident #13's [redacted] management, the RN/UM stated the resident was diagnosed with [redacted] (when [redacted]) and was constantly in [redacted]. The RN/UM reiterated that there was family dynamics involved.

During a telephone interview on 6/7/2023 at 1:55 PM, the RN floor nurse explained the nursing practice when administering [redacted]. The RN stated the nurse assesses the resident's [redacted] and administers the [redacted] per the physician's order. The nurse is supposed to sign the declining sheet when the medication is removed from the bottle. The MAR is signed after the nurse administers the medication to the resident.

During an interview on 6/7/2023 at 3:19 PM, the Director of Nursing (DON) stated the nurse should review the physician's order and follow the five rights when administering medication. The five rights include the right resident, right medication, right dose, right time, and right route. The DON stated that he expected the nurse to sign the declining sheet once they removed the dosage from the [redacted] bottle. The nurses are expected to sign the MAR after administering the medication to the resident. The DON added that there should not be any blanks on the MAR.

During an interview on 6/8/2023 at 9:50 AM, Resident #13's physician, who is also the facility's Medical Director (MD), stated the resident had an advanced [redacted] diagnosis, was malnourished when admitted, and that she assisted the family with end-of-life management and goals of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 61	F 697		

The resident did not want to do further [redacted] treatments and just wanted to be comfortable. The MD added that family dynamics were involved and that the resident's [redacted] did not want the resident on [redacted], while the resident's Power of Attorney (POA) wanted [redacted] to be administered for [redacted] management. The MD stated that she informed the resident's [redacted] that the resident was not being overmedicated and that they were trying to keep him/her comfortable. The physician indicated that she had frequent communication with the resident's family, provided education about the resident's disease process and that the resident's [redacted] needed to be managed . Due to the resident's lifestyle and medical history, he/she needed higher doses of [redacted] [redacted] management. The MD added that Resident #13's appetite improved once the [redacted] had been controlled. The MD stated that her goal was to control the resident's symptoms and that the [redacted] dose was eventually lowered. The MD further stated that she expected the nurses to administer Resident #13's medication per the physician's order.

During a follow-up interview on 6/8/2023 at 11:59 AM, the DON stated that he expected nurses to administer the resident's medication per the physician's order. The DON reiterated that there should be no blanks and that the medication should have been administered. The DON stated the MAR and declining sheet should match. The nurses are supposed to document all removal of narcotics on the declining sheet. The DON could not provide an answer as to why the nurses did not sign the MAR and/or the declining sheet on the aforementioned dates.

During a follow-up interview on 6/9/2023 at 12:45

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 62	F 697		

PM, the RN/UM, who was responsible for administering Resident #13's [redacted] on [redacted], stated that she would sometimes work the cart and that she administered the resident's medication per the physician order. The RN/UM added that the declining sheet should be signed when the medication is removed from the [redacted] bottle. When questioned about Resident #13's [redacted] medication administration, the RN/UM stated that she administered the medication as ordered but must have forgotten to sign the declining sheet.

No further information was provided by the facility.

Review of the facility's "Controlled Substances Policy," revised on 1/2023, indicated under "Policy" that it was "the policy of this facility to promote safe, high-quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances." The policy is revealed under "General Protocols," "4. The Controlled Substance Administration Record (CSAR) [declining sheet] serves the dual purpose of recording both the narcotic disposition and patient administration. 5. The licensed nurse administering a controlled substance will document the administration in the patient's electronic medical record, i.e. Medication Administration Record [MAR] and/or Progress Notes." The policy further revealed under "Documenting Administration Controlled Substances," that any facility nurse who administers a Controlled Substance (CS) to a resident will document on the resident's applicable declining sheet the date and time the CS was removed and the number of remaining doses. The nurse will also document the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 63 administration in the resident's MAR.	F 697		
F 726 SS=F	N.J.A.C.: 8:39-27.1(a) Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		6/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 64 This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ164590 Based on observation, interviews, medical record review and review of pertinent facility documentation on 6/5/2023, 6/6/2023, 6/7/2023, 6/8/2023, 6/9/2023 and 6/12/2023, it was determined that the facility failed to ensure a process was in place and followed to ensure untrained staff without sufficient competencies were meeting the health and/or safety needs of one or more residents. Hospitality Aides (HAs) were competent to provide resident care by failing to ensure: a.) HAs were enrolled in a State-approved training and competency program, and b.) a system was in place to ensure all HAs received the appropriate training and deemed eligible to provide resident care, which included, but was not limited to; two person transfers, bathing and feeding of dependent residents. This was identified for 15 employees, who provided facility wide direct resident care on 4 of 4 units from 5/11/2023 through 6/5/2023, were reviewed. On 6/8/2023, the Surveyor reviewed the Assignment Sheets from 5/11/2023 through the present. The assignment sheets showed a total of 15 uncertified staff. The Surveyor then requested the uncertified staff Personnel files from the Administrator and noted the following documentation was missing from the Personnel files for the HAs at the time of the survey: HA #1: Under Human Resources New Hire Form (HRNHF)" revealed a "Date of Hire (DOH)" [redacted] Under "Professional Reference (PR)" only noted the "Applicant's Name:","Applicant	F 726	I. - Hospitality Aide (HA) #1, HA #2, HA #3, HA #4, HA #5, HA #6, HA #7, HA #8, HA #9, HA #10, HA #11, HA #12, HA #13; HA #14; HA #15 removed from the facility on 6/7/23 and as of 6/12/23 all were terminated from employment at Merwick; before facility received 2567 report. - A facility general orientation program as well as nursing orientation/training program is in place. All newly hired employees are required to complete the facility orientation program. All newly hired nursing staff, including RNs, LPNs, CNAs in addition to the general orientation, completed nursing orientation, including clinical validation competencies training immediately. II. - All residents have the potential to be affected by the same deficient practice. III. - HR/Designee completed full audit on all employees to ensure completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program; audit started on 6/6/23. - Facility Educator/Designee will ensure that all newly hired licensed nursing staff, including RNs, LPNs, CNAs in addition to the general orientation, complete nursing orientation, including clinical validation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 65 Signature:" and "Date:" 4/7/2023 no references contacted. HA #2: Under HRNHF revealed a DOH 5/4/2023. Under PR noted as blank, no references contacted. HA #3: Under HRNHF revealed a DOH 4/17/2023. Under PR noted only the "Applicant's Name", "Applicant Signature:" and "Date" [redacted], no references were contacted. HA #4: Under PR revealed the "Applicant's Signature:" and "Date" July 6, 2022, no references were contacted. HA #5: Under "Application for Employment" dated [redacted] revealed "Position(s) Applied for Hospitality". Under undated "HR New Hire Form" revealed Under "Department" "Nursing" and Under "Position" as "Hospitality". Under "Position Title: Certified Nurse Aide" included "Department: Nursing" Reports to: Charge Nurse/Supervisor/Nursing Administrator" revealed HA #5 signature on [redacted]. There was no Certification number noted in the Personnel file. HA #5 was noted as a Hospitality Liaison on the [redacted] provided by the RHRM. Under PR revealed a date of [redacted] only documented 1 reference. HA #6: Under "Application for Employment" dated 5/5/2-23 revealed "Position(s) Applied for Care Give H.H.A. (Home Health Aide)." Under "HR New Hire Form" revealed a "Date of Hire" [redacted] revealed "Position": "TNA (Temporary Nursing Assistant)." There was no Job Description noted in the Personnel File. Under PR revealed the "Applicant's Signature:"	F 726	competencies training immediately. - Facility Educator/Designee will continue to facilitate general orientation for all staff and nursing orientation program for RNs, LPNs, CNAs. - Facility Educator/Designee started in-services for the HR and nursing staff on 6/12/23 on following topics: a. Facility Direct Care providers, their credentials and responsibilities based on job description and facility policies and procedures. b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any. d. Unit Managers/Nursing Supervisors/Charge nurses' responsibilities. e. Facility training program for nursing and non-nursing staff. - Facility Educator/Designee will continue in-services on the following topics: a. Facility Direct Care providers, their credentials and responsibilities based on job description and facility policies and procedures. b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 66 and "Date" 5/5/2023, no references were contacted. HA #7: Under "Application for Employment" dated 12/26/2022 revealed "Position applied for CNA/TNA." Under undated HRNHF revealed "Department" as "Float" and Under "Position" "NA (Nursing Assistant)." There was no Job Description noted in the Personnel File. Under PR revealed blank PR with no references contacted. HA #8: Under undated "Application for Employment" revealed no references listed. Under PR revealed blank spaces with no references contacted. HA #9: Under "Application for Employment" dated 5/29/2023 revealed only 1 reference listed. Under HRNHF revealed a "Date of Hire" [redacted] revealed "Position" "Hospitality." Under undated "Position Title: Hospitality Liaison" included "Department: Nursing" Reports to: Charge Nurse/Supervisor/Nursing Administrator" revealed no second page or employee signature on the Job Description. Under PR revealed blanks with no references contacted. HA #10: Under "Application for Employment" dated 5/29/2023 revealed "Position(s) Applied For CHHA" and only 1 reference listed. Under HRNHF revealed a "Date of Hire" [redacted] revealed "Position" "Hospitality." Under undated "Position Title: Hospitality Liaison" revealed no second page or employee signature on the Job Description. Under PR revealed blanks with no references contacted. HA #11: There was no PR in the Personnel File.	F 726	d. Unit Managers/Nursing Supervisors/Charge nurses' responsibilities. e. Facility training program for nursing and non-nursing staff. IV. - HR/Designee will continue to conduct random audits for newly hired employees to ensure completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - HR/Designee will continue to conduct random audits for all newly hired employees to ensure completion of the facility general orientation program; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - ADON/Designee will continue to conduct random audits for all newly hired licensed nursing staff, including RNs, LPNs, CNAs to ensure, in addition to the general orientation, completion of nursing orientation, including clinical validation competencies and mandatory trainings; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Administrator/Designee will conduct spot audits on completion of all required documentations/orientation paperwork/validation of certification, if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 67 HA #12: Under "Application for Employment" revealed a date, 6/1/2023. There was no Criminal History Background Check noted in the Personnel file. Under "Position Title: Certified Nurse Aide" included "Department: Nursing" Reports to: Charge Nurse/Supervisor/Nursing Administrator" revealed HA #12 signature on [redacted]. There was no CNA Certification noted in the Personnel file. HA #12 is noted as a "Hospitality Liaison" on the [redacted] list provided by the RHRM. Under PR revealed only the "Applicant's Signature:" and "Date" of [redacted], no references were contacted. HA #13: Under "Application for Employment" dated [redacted] revealed no references listed. There was no PR in the Personnel File. HA #14: Under undated "Position Title: Hospitality Liaison" revealed no second page or employee signature on the Job Description. Under PR only revealed 1 reference contacted. HA #15: Under undated "Position Title: Hospitality Liaison" revealed no second page or employee signature on the Job Description. There was no PR in the Personnel File. During an interview on 6/5/2023 at 2:23 p.m., the Regional Human Resources Manager (RHRM) stated, "Certified Home Health Aides (CHHAs) are Hospitality Aides, [they] assist with Activities of Daily Living (ADLs), but no transferring [of residents]. The HA[s] need to work with a certified person to do a transfer." In the same interview, the RHRM continued to	F 726	any, and to ensure that all newly hired employees complete the facility orientation program as well as all newly hired nursing staff complete nursing orientation, including clinical validation competencies and mandatory trainings; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits 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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 68	F 726		

say "the Supervisor, the Unit Manager (UM), Director of Nursing (DON), Assistant Director of Nursing (ADON) or Department Head reviews the job description with the HAs and both sign off on it and [a copy] is kept in the personnel file . We don't offer the Certified Nursing Assistant (CNA) class here I give the numbers [for staff] to call. The staff brings their certification and the nurses follow up with them."

During an interview on 6/5/2023 at 5:35 p.m. when the Surveyor asked who ensures the TNAs and HAs receive the required training, the Administrator replied "the Nursing Staff Educator ensures the TNA[s] and HA[s] receive the required training." She continued to say, between the months of February to April, 2023, the Regional Corporate Clinical Nurse (RCCN) was responsible for ensuring the required training was done."

During an interview on 6/5/2023 at 5:40 p.m., when the Surveyor asked about the TNA and HA training, the RCCN stated "I provided education and competencies on ADLs to the TNAs. CHHAs are HAs, [they] don't do direct care, TNAs and HAs are always buddied up with Certified Nursing Assistants (CNAs) as long as they are in the facility and until they become certified."

In the same interview, the RCCN stated "[the] TNAs are used after taking [a] 8 hours [of] class and enrolled in a school. I'm not sure if the TNAs now are enrolled in school. If [the TNA is] not able to enroll in [a] CNA school, we switched them over to hospitality aide and will be a buddy system. They should not be doing direct care."

In the same interview, when the surveyor asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 69	F 726		

about documentation, the RCCN replied "there is no documentation about [the] buddy system, it's only [noted] on [the] staffing sheets."

During an interview on 6/6/2023 at 2:40 p.m., the RHRD stated "Criminal History Background Checks and Results should be in the [Personnel] File. Any documentation before 4/3/2023 I can't speak about because I wasn't hired yet."

In the same interview, she continued to say "it was a general orientation, not a hiring orientation, staff would complete hiring paperwork and start to work. Orientation has not happened in a while, but I don't know how long."

On 6/7/2023 at 2:01 p.m., the RHRM stated the job description for Hospitality Liaison and Hospitality Aides are the same position in the computer."

On 6/8/2023 at 1:20 p.m., the RHRM provided another list of 13 HAs to the Surveyor, then upon review, 2 more were added for a total of 15.

On 6/8/2023 at 2:42 p.m., when the Surveyor asked about the current HA list, the Administrator replied "the CHHA/HA list given on Monday, 6/5/2023 was taken from the shared drive [on the computer] but it was not updated."

During an interview on 6/12/2023 at 11:04 a.m., the Registered Nurse Educator stated "when I started [in May], the facility nurse was to become certified and the HAs would enroll in [CNA] school here, some HAs enrolled, but I don't know who, where or what place." She continued to say "the new hire [staff] goes to Human Resources (HR) first about [the] job position, then the new staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 70	F 726		

comes to me for onboarding and education, I'm not involved with the schooling. I do the competencies."

A review of the undated "Position Title" Regional Human Resources Manager" revealed Under "Responsibilities/Accountabilities:" included: " ...Ensures compliance with federal, state, and local employment laws and regulations, best practices to maintain compliance ...Knowledge of state and federal laws ...On-boarding, orientation, and employment verification of new employees; ...Knowledge of requirements of each position; ..."

A review of the undated "Position Title: Staff Educator: revealed Under "Responsibilities and Accountabilities:" included: "Plan, develop, direct, evaluate, and coordinate educational and on-the-job training programs ...Develop, evaluate, and control the quality of in-service educational programs sin accordance with established policies and procedures ...Perform administrative requirements such as completing necessary forms, reports, class attendance and subject records, etc ...Develop and participate in the planning, conducting, and scheduling of orientation programs that orient newly hired personnel to their position, the facility's policies and procedures, resident rights and responsibilities, etc. ..."

A review of the undated facility policy titled "Employee Care Partner Hiring Policy" revealed the following: Under "Our Purpose" included "As a caring community, we believe in created empowered care partner teams who will support our communities in creating meaningful relationships with all people who live and work in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 726	Continued From page 71 the homes. We will hire qualified candidates whose values and attitudes align with our core value of promoting honor, dignity and respect for all care partners in the homes." Under "Our Strategies" included " ...5.All candidates must complete and sign a job application form. 6. The following criteria will be considered in determining whether an applicant is qualified for a particular job position: a. Ability to perform the essential functions of the job ...c. Valid certifications and licenses. 7. Nursing Positions: Department Head, Nursing Services Mentor (Director of Nursing) and Community Mentor (administrator) will interview candidates and discuss qualifications for potential hire ...11. Upon final selection of the candidate the application is forwarded to the Staffing Coordinator to conduct reference checks. A minimum of two (2) reference checks are required for each applicant ...15. Every effort must be made to contact previous employers expeditiously to ensure we do not lose qualified candidates ...17. The Team Member Services Manager will conduct a Criminal Background Check (CBC) on all applicants being considered for employment. If the CBC is unfavorable the hiring process ends for the candidate ...22. All policies, procedures, benefits and conditions of employment must be reviewed with all new hires. All policies and procedures must be signed and dated by the new hire ..."	F 726		
F 728 SS=L	N.J.A.C. 8.39-43.2 Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides-	F 728		6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 72 §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ164590	F 728	I. - Hospitality Aide (HA) #1, HA #2, HA #3, HA #4, HA #5, HA #6, HA #7, HA #8, HA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 73 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, and 6/7/2023, it was determined that the facility failed to ensure a process was in place and followed to ensure untrained staff without sufficient competencies were meeting the health and/or safety needs of one or more residents. Hospitality Aides (HAs), which include (Certified Home Health Aides-CHHAs and Temporary Nurses' Aides-TNAs), were competent to provide Resident care by failing to ensure: a.) HAs were enrolled in a State-approved training and competency program, and b.) a system was in place to ensure all HAs received the appropriate training and were deemed eligible to provide resident care, which included, but was not limited to, assisting residents with toilet care, bathing and turning and repositioning residents. On 6/5/2023 at 11:28 a.m., the Surveyor observed an HA (HA #1) assist a resident (Resident #2) from the bathroom with his/her walker and then transferred the Resident from a standing position to a sitting position into a chair in the corner of the room. During an interview on 6/5/2023 at 11:29 a.m., the HA said she had 18 residents today, all total care, and she does the same duties as the Certified Nursing Assistant (C.N.A.). On 6/5/2023 at 6:42 p.m., the Surveyor observed HA #2 assisted CNA #1 with bathing when she helped reposition a resident (Resident #7) in bed. The facility's failure to have a system in place to ensure that HAs were appropriately trained and certified to provide resident care placed all residents at risk for the likelihood that serious injury, serious harm, and death may occur, resulting in an Immediate Jeopardy situation (IJ). This placed all residents in an IJ situation. The IJ	F 728	#9, HA #10, HA #11, HA #12, HA #13; HA #14; HA #15 removed from the facility on 6/7/23 and as of 6/12/23 all were terminated from employment at Merwick; before facility received 2567 report. -On 6/5/23, a revised facility orientation program was in place and followed as per facility policies and procedures, State and Federal regulations. Nursing orientation/clinical validation competencies were in place. - On 6/5/23, HR/Designee audited all staff assigned to the nursing department to separate CNA licensed from non-licensed to generate a list of the HAs immediately. -On 6/5/23, HR/Facility Educator separated all Hospitality Aides to ones with CHHA license and non-licensed ones. Out of 10 HAs 7 had active Certified Home Health Assistant (CHHA) license. Out of 10 newly hired HAs 4 completed general orientation and clinical competency validation program. -On 6/5/23, a facility general orientation program as well as nursing orientation/training program was in place. All newly hired employees were required to complete the facility orientation program. All newly hired licensed nursing staff, including RNs, LPNs, CNAs and HAs, in addition to the general orientation, completed nursing orientation, including clinical validation competencies training immediately, on 6/5/23. -On 6/5/23, all HAs were re-in-serviced on hospitality aide scope of services as per the facility policies and procedures, State and Federal regulations. -On 6/5/23, HR ensured that all facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 74 was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (D.O.N.) on 6/5/2023 at 8:00 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 6/5/2023 and continued through 6/7/2023, when the facility removed all HAs from the floor. On 6/7/2023, the Removal Plan was implemented. The facility implemented the Removal Plan, which included removing all uncertified aides [H.A.s] from the floor and educating all staff that uncertified aides [H.A.s] are not to be in resident care areas. So, the noncompliance remained on 06/7/2023 as a level F for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This deficient practice was identified for 15 Hospitality Aides (H.A.s) reviewed that provided care on 4 of 4 resident units from 5/11/2023 through 6/5/2023 and was evidenced by the following: On 6/5/2023 at 10:37 a.m., the Surveyor took a tour of the first-floor unit and requested the Assignment Sheet (AS) for the 7:00 a.m. - 3:00 p.m. shift. The AS revealed the unit "3 CNA Assignment" with 3 names listed for each of the 3 hallways on the unit, including HA #1 with her own Assignment of 17 residents. At 6:23 p.m., the Surveyor took a 2nd tour of the unit and requested the AS for the 3:00 p.m.-11:00 p.m. shift for the "3 CNA Assignment," revealing 3 CNA names per hallway, to include HA #2 with her own Assignment of 20 residents.	F 728	policies and procedures in hiring process were followed to make sure that all forms completed, and all required documents collected/verified/signed. -HR/Designee completed immediate audit of current nursing employees files for completion of the hiring process, including signing the job description and having valid licenses on 6/5/23. -HR/Facility Educator followed facility hiring process and general facility orientation for newly hired employees, including RNs, LPNs, NAs and HAs starting immediately on 6/5/23; all newly hired nursing staff, including RNs, LPNs, CNAs, NAs and HAs will completed nursing orientation, and all required clinical validation competencies. -On 6/5/23, DON/Designee immediately audited all Risk Management reports to identify if any non-licensed nursing staff were involved. Summary/description of event will be provided to include any evidence that led to a serious adverse outcome if any non-licensed nursing staff were involved in any incident events. As per completed audit, none of the HAs were involved in any facility resident incidents. -On 6/5/23, facility Educator/Designee continued facilitating training sessions for all nursing/non-nursing staff as per established facility training program. -On 6/7/23 at 4:20PM, all Hospitality Aides (HAs), who were Certified Home Health Aides as well, were off the floor. All HAs were not to be in the residents care areas. - On 6/7/23, all Hospitality Aides were removed/discharged from the facility and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 75 On 6/5/2023 at 11:28 a.m., the Surveyor observed HA #1, as noted on her employee badge, provide assistance to a Resident (Resident #2) walking from the bathroom with his/her walker across the room and provided transfer assistance from a standing position into a sitting position to a chair in the corner of the room. On 6/5/2023 at 6:42 p.m., the Surveyor observed HA #2 assisted CNA #1 with bathing when she helped reposition a resident (Resident #7) in bed. HA #2 was observed helping CNA #1 reposition the Resident up in bed by assisting with the [redacted] (sheet located under the Resident to help with movement) to move the Resident towards the head of the bed and also helped reposition his/her [redacted] during bathing. 1. According to the Admission Record (AR), Resident #2 was originally admitted to the facility on [redacted] 2 and readmitted on [redacted] with diagnoses which included but were not limited to [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted] Resident # 2 had a Brief Interview of Mental Status (BIMS) score [redacted], which indicated the Resident was [redacted]. The MDS also showed Resident #2 needed [redacted] assistance with most Activities of Daily Living (ADLs), including transferring and toilet use. 2. According to the AR, Resident #7 was admitted	F 728	by 6/12/23 - all HAs were terminated from Merwick Care and Rehabilitation Center employment. - On 6/7/23, full audit of all non-certified staff vs facility incident reports was completed as following: a. Timecards of all non-certified employees printed, starting from the date of hire of each employee. b. All facility incidents were printed starting from 2/4/2022 - the date of hire of the longest staying employee. c. All facility incidents were cross checked against all time cards of each employee to rule out any involvement of the non-certified employees in any facility incidents. d. All data was recorded in the Risk Management Reports of Incidents vs Staff Involvement tracking tool. e. Based on the collected information out of 15 non-certified employees in the list 0 were involved in any resident incidents. - Results of the audit was provided to the DOH Survey team. II. - All residents have the potential to be affected by the same deficient practice. III. - ADON/Designee will complete full audit on all employees to ensure completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program. - Facility Educator/Designee will ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 76 to the facility on [redacted] with diagnoses which included but were not limited to [redacted] With [redacted]. According to the MDS, an assessment tool dated Resident # 7 had a BIMS score of [redacted], which indicated the Resident was [redacted]. The MDS also showed Resident #7 needed [redacted] I assistance with most Activities of Daily Living (ADLs), including bed mobility and bathing. On 6/5/2023 at 3:00 p.m., the Administrator provided a list of current Hospitality Aides (H.A.s) with 9 names. On 6/8/2023 at 1:20 p.m., the Regional Human Resources Manager (RHRM) provided a 2nd list of Hospitality Aides/Hospitality Liaisons with 5 additional uncertified aides for a total of 14. A review of Daily Schedule Sheets (DSS) dated [redacted] through [redacted] revealed a total of 15 uncertified aides (H.A.s) were scheduled as "Nursing Assistants" with their own assignments of residents on all 3 shifts on all units to work as follows: HA #1 on the 7:00 a.m.-3:00 p.m. shift on 5/11/2023, 5/12/2023, 5/16/2023, 5/18/2023, 5/19/2023, 5/21/2023, 5/22/2023, 5/23/2023, 5/25/2023, 5/26/2023, 5/29/2023, 5/30/2023, 6/1/2023, 6/2/2023, 6/4/2023, 6/5/2023 and on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/16/2023, 5/18/2023, 5/21/2023, 5/23/2023, 5/25/2023, 5/30/2023, 6/1/2023, 6/4/2023.	F 728	that all newly hired licensed nursing staff, including RNs, LPNs, CNAs, in addition to the general orientation, complete nursing orientation, including clinical validation competencies training immediately. - Facility Educator/Designee will continue to facilitate general orientation for all staff and nursing orientation program for RNs, LPNs, CNAs. -Starting on 6/5/23, Facility Educator/Designee in-serviced all Unit Managers on their responsibilities as per job description, including that unit manager was responsible for supervising units nursing staff, including HAs; Unit Managers were responsible for assuring daily staffing assignments; if Unit Manager was not available, charge nurse would be responsible for the daily assignment. All nursing, including RNs, LPNs, CNAs, and HAs must complete general orientation, clinical validation competencies and orientation to the Unit with Unit Manager/Nursing Supervisor/Charge Nurse. Unit Manager performs all assigned duties, including responsibility for assuring daily staffing assignments based on the job description that they receive/sign upon hiring; signage of job description is part of the onboarding during the hiring process. Hospitality Aides provide non-direct care on the unit. -Training sessions on Removal Pans for F 728 started on 6/5/23. Administrator facilitated in-service for the management team and facility educator took over to facilitate in-service for the staff. Additional topics presented: a. Facility Direct Care providers, their	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 77 HA #2 on the 7:00 a.m.-3:00 p.m. shift on 5/11/2023, 5/12/2023, 5/17/2023, 5/18/2023, 5/19/2023, 5/20/2023, 5/21/2023, 5/22/2023, 5/24/2023, 5/25/2023, 5/26/2023, 5/29/2023, 5/30/2023, 5/31/2023, 6/1/2023, 6/2/2023, 6/3/2023, 6/4/2023, 6/5/2023 and on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/18/2023, 5/22/2023, 5/23/2023, 5/25/2023, 5/29/2023, 5/31/2023 and 6/5/2023. HA #3 on the 7:00 a.m.-3:00 p.m. shift on 5/11/2023, 5/12/2023, 5/16/2023, 5/18/2023, 5/19/2023, 5/21/2023, 5/22/2023, 5/23/2023, 5/25/2023, 5/26/2023, 5/28/2023, 5/29/2023, 5/30/2023, 6/1/2023, 6/2/2023, 6/4/2023, 6/5/2023 and on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/18/2023, 5/21/2023, 5/23/2023, 5/25/2023, 5/30/2023, 6/1/2023, 6/4/2023. HA #4 on the 7:00 a.m.-3:00 p.m. shift on 5/18/2023. HA #5 on the 7:00 a.m.- 3:00 p.m. shift on 6/3/2023 and on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/13/2023, 5/17/2023, 5/18/2023, 5/20/2023, 5/22/2023, 5/24/2023, 5/25/2023, 5/27/2023, 5/31/2023, 6/1/2023 and 6/5/2023. HA #6 on the 7:00 a.m.-3:00 p.m. shift and the 3:00 p.m.-11:00 p.m. shift on 5/26/2023, 5/27/2023, 5/28/2023, 5/29/2023 and 11:00 p.m.-7:00 p.m. on 5/26/2023, 5/28/2023, 5/29/2023, 5/31/2023, 6/1/2023, 6/2/2023 and 6/5/2023. HA #7 on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/16/2023, 5/17/2023, 5/18/2023, 5/19/2023, 5/20/2023, 5/22/2023, 5/23/2023,	F 728	credentials and responsibilities based on job description and facility policies and procedures. b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any. d. Unit Managers/Nursing Supervisors/Charge nurse responsibilities. e. Facility training program for nursing and non-nursing staff. - Facility Educator/Designee will continue in-services on the following topics: a. Facility Direct Care providers, their credentials and responsibilities based on job description and facility policies and procedures. b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any. d. Unit Managers/Nursing Supervisors/Charge nurses' responsibilities. e. Facility training program for nursing and non-nursing staff. IV. - DON/Designee will continue to conduct audits for newly hired employees to ensure completion of all required	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 78 5/24/2023, 5/25/2023, 5/27/2023, 5/29/2023, 6/1/2023, 6/3/2023, 6/5/2023 and on the 11:00 p.m.-7:00 a.m. shift on 5/11/2023, 5/16/2023, 5/17/2023, 5/18/2023, 5/20/2023, 5/22/2023, 5/23/2023, 5/25/2023, 5/26/2023, 5/27/2023, 5/29/2023, 5/31/2023, 6/5/2023. HA #8 on the 7:00 a.m.-3:00 p.m. shift on 5/11/2023, 5/12/2023, 5/16/2023, 5/18/2023, 5/19/2023, 5/21/2023, 5/22/2023, 5/23/2023, 5/25/2023, 5/26/2023, 5/28/2023, 5/29/2023, 5/30/2023, 6/1/2023, 6/2/2023, 6/4/2023, 6/5/2023 and on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/16/2023, 5/18/2023, 5/21/2023, 5/23/2023, 5/25/2023, 5/30/2023, 6/1/2023 and 6/4/2023. HA #9 on the 11:00 p.m.-7:00 a.m. shift on 6/4/2023. HA #10 on the 11:00 p.m.-7:00 a.m. on 6/2/2023. HA #11 on 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/12/2023, 5/16/2023, 5/17/2023, 5/18/2023, 5/19/2023, 5/20/2023, 5/21/2023, 5/24/2023, 5/25/2023, 5/30/2023, 6/1/2023, 6/2/2023, 6/3/2023, 6/4/2023 and on the 11:00 p.m.-7:00 a.m. shift on 5/16/2023, 5/19/2023, 5/20/2023, 5/26/2023, 5/28/2023, 6/1/2023, 6/2/2023 and 6/4/2023. HA #12 on the 3:00 p.m.-11:00 p.m. shift on 5/11/2023, 5/12/2023, 5/15/2023, 5/16/2023, 5/17/2023, 5/18/2023, 5/19/2023, 5/22/2023, 5/23/2023, 5/24/2023, 5/25/2023, 5/26/2023, 5/29/2023, 5/30/2023, 5/31/2023, 6/1/2023, 6/2/2023, 6/5/2023 and on the 11:00 p.m.-7:00 a.m. on 5/11/2023, 5/12/2023, 5/15/2023, 5/16/2023. 5/17/2023, 5/18/2023, 5/19/2023,	F 728	documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will continue to conduct audits for all newly hired employees to ensure completion of the facility general orientation program; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Facility Educator/Designee will continue to conduct audits for all newly hired nursing staff, including RNs, LPNs, CNAs to ensure, in addition to the general orientation, completion of nursing orientation, including clinical validation competencies and mandatory trainings; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Administrator/Designee will conduct spot audits on completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program as well as all newly hired nursing staff complete nursing orientation, including clinical validation competencies and mandatory trainings; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits will be presented to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 79 5/20/2023, 5/21/2023, 5/22/2023, 5/23/2023, 5/24/2023, 5/25/2023, 5/29/2023, 5/30/2023, 5/31/2023, 6/1/2023, 6/2/2023, 6/3/2023, 6/4/2023 and 6/5/2023. HA #13 on the 7:00 a.m.-3:00 p.m. shift on 5/11/2023, 5/12/2023, 5/18/2023, 5/19/2023, 5/20/2023, 5/21/2023, 5/22/2023, 5/24/2023, 5/25/2023, 5/26/2023, 5/29/2023, 5/20/2023, 5/31/2023, 6/1/2023, 6/3/2023, 6/4/2023 and 6/5/2023. HA #14 on the 11:00 p.m.-7:00 a.m. shift on 6/4/2023. A review of a timesheet for HA #15 revealed "Selected Range of Dates 06/01/2023 - 06/08/2023" included Under "Date" 6/06" and "6/07" Under "Schedule" "7:00 a.m.-3:30 p.m." Under "In," "7:00 a.m. (a.m.) and "Out," "3:30 p.m. (p.m.) and Under "Daily" revealed, "8.0" for both dates revealing Under "Amount" "23.5" [hours]. During an interview on 6/5/2023 at 11:29 a.m., HA #1 stated, "I'm a Certified Home Health Aide (CHHA). I have been working since April. I usually have 18 residents, all total care on my Assignment." When the Surveyor asked if she had done any CNA classes, she replied, "I haven't done any CNA classes yet; I will do them soon." In the same interview, when the Surveyor asked her about her duties, HA #1 replied, "I do the CNA duties, I provide incontinence care every 2 hours, and as [the] patient [Resident] needs it, I do showers for residents, I write my tasks on the Activities of Daily Living (ADL) sheet, I answer the call bell on this side [hallway], I provide meal	F 728	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 _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 80	F 728		

assistance. I do everything a CNA does..."

During an interview on 6/5/2023 at 11:49 a.m., the Unit Manager /Registered Nurse (UM/RN) stated today that she has HA (HA #1) who is going through training. The UM/RN further stated the HA has her own Assignment. She added that each aide has a hallway assigned.

During an interview on 6/5/2023 at 12:06 p.m., with the Nursing Supervisor (NS), in the presence of the Staffing Coordinator, she stated we use Temporary Nurses' Aides (T.N.A.s) on the floor; there are ADL Competency sheets [to be completed] and the goal is to [for them] to be enrolled in [a] CNA program."

In the same interview, the NS stated, "Most of the TNAs & Hospitality Aides (HAs) are home health aides, [they] have some training, and the Registered Nurse (RN) signs off [on the training]. Hospitality Aides serve water, pass trays, assist with care, and have passed some competencies." She continued, "TNA can do as much as a CNA; TNA is never on the floor by themselves. Once the TNA passes competencies, [the] CNA does not need to be in the room with the TNAs; the TNA can have their own Assignment of residents once competencies are passed based on the Unit Manager. We [the facility] are following the guidance dated 5/12/2023."

During an interview on 6/5/2023 at 12:46 p.m., when asked if she assisted the TNA (HA #1) working on the floor today, CNA #2 working on the day shift on the 1st floor stated that she was "told by the nurse the TNA (HA #1) has been here for a couple of months, so I don't provide assistance to her."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 81 During an interview at 12:57 p.m., CNA #3, the other CNA working on the day shift on the [redacted] floor, stated, "Today, I did not provide assistance to the TNA (HA #1)." During an interview on 6/5/2023 at 1:17 p.m., when the Surveyor asked her if a TNA could work alone, the RN on the [redacted] unit stated, "Yes, if [a] TNA pass[ed] competencies, they can work alone, once passed, the nurse doesn't sign off on any paperwork, [but] offer[s] help if needed." During an interview on 6/5/2023 at 1:57 p.m., the Unit Manager/Registered Nurse (UM/RN) stated, "The nurse doesn't sign off on any competencies; the nurse educator is in charge of [the] competencies." She continued to say that the Administrator wanted [the] UM to train TNAs, but UMs had no time [to train]. The UM/RN further stated, "I don't know if competencies are done; I had no idea of [a] CHHA/ [HA] on [the] floor. I thought TNAs were ready to go [work] when they arrived on the floor. Prior to the current staff educator, I don't know who trained the TNAs, [staff are] hired and [have] no official orientation to [the] company, go to [the]floor and learn on [the] floor." In the same interview, the UM/RN stated, "I felt [the] TNAs needed to be trained; I was told there'd be a CNA training here through the school here, but [it was] not initiated yet." During an interview on 6/5/2023 at 2:23 p.m., when asked about TNAs, the Regional Human Resources Manager (RHRM) stated, "We shouldn't have any TNAs now; they should be in the CNA class or not working. Hospitality Aides	F 728		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 82	F 728		

(H.A.s) assist with ADLs, but no transferring. HA needs to have someone certified, CNA or nurse, with them to transfer. HA can pass trays and brush hair, but no feeding. The CHHAs are the HAs. The CHHAs need a certified person to work with them. We don't offer the CNA class here; I give the [phone] numbers to call."

In the same interview, when the Surveyor asked about who verifies the staff has required certification and knows their job duties, the RHRM replied, "The Supervisor, UM, Director of Nursing (D.O.N.), Assistant Director of Nursing (ADON) or Department Head, review the job description with [the] HA and both sign off on it, and it is kept in [their] file. The staff brings proof of their certification, and the nurses follow up with them."

When the Surveyor asked about the TNA name badge, the RHRM replied, "If there [was a] TNA on [the] floor, it would say TNA. If a CHHA was hired, [the] badge would say Hospitality Aide." The RHRM continued, "H.A.s are supervisors, not hands-on care; they observe."

During an interview on 6/5/2023 at 2:44 p.m., the DON stated, "We hire TNA. We are in the process of having a CNA class here. We train TNAs by following CNAs, and [they] do competencies. TNAs don't have an assignment, [they] answer call light, provide ice water and pass out trays during mealtimes." Hospitality Aides do the same duties as [a] TNA; HA wants to become CNAs."

In the same interview, the DON stated, "We do hire CHHAs, [they] are hired as Hospitality Aides (H.A.s) because [they] are not certified by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 83	F 728		

state to work independently." When the Surveyor asked how the nurse knew if the aide was a T.N.A. or a CNA, the DON stated, "The nurse on the floor knows by the assignment sheet if the aide is a T.N.A. or CNA.."

In the same interview, when the Surveyor showed the DON the 2 DOH memos dated May 12, 2023, the DON stated, "Yeah, these are [the] 2 memos followed by [the] facility. [The] State will probably extend it again, and we'll be in compliance."

During an interview on 6/5/2023 at 4:50 p.m., when the Surveyor asked her if a TNA could provide care, the Administrator replied, "I believe not; TNA shadows a CNA."

In the same interview, when the Surveyor asked about the duties of the HAs and CHHAs, the Administrator stated, "HA don't provide care, only ice water, and I need to check if a HA can assist a resident to the bathroom; I think a certified person, a nurse or C.N.A. [is] to do care. CHHA and HA are the same. CHHA is a HA CHHA have [their] own license but don't provide care. NA (Nursing Aides) don't have skills; I let them go [from employment]. We created HAs. We are waiting to provide [CNA] classes here."

In a second interview on 6/5/2023 at 5:35 p.m., when the Surveyor asked the Administrator who ensures the TNA and HA receive the required training, the Administrator replied, "The Nursing Staff Educator (NSE)." The NSE was unavailable between March and May, so the Regional Corporate Clinical Nurse (RCCN) was responsible.

During an interview on 6/5/2023 at 5:40 p.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 84	F 728		

RCCN stated, "The State extended deadlines; I provided education to TNAs on competencies for ADLs. After training, the TNA is buddied up [paired] with a CNA for 2-3 weeks; then, I would do another competency with the UM... TNAs are used after taking 8 hours of class and enrolled in a school, buddied up, doesn't stop until certified. I'm not sure if the TNAs are now enrolled in school; I have to check. Some were terminated if not [enrolled] in school. Prior to 2021, [TNA] took [s] [an] 8-hour class and enrolled in a CNA program. If they are unable to enroll in CNA school, we will switch them to HA, which will be a buddy system. There's no documentation of a buddy system; it's only on [the] staffing sheets." However, the RCCN could not provide evidence that the TNA was enrolled in an NJ State-approved training program.

During the same interview, when the Surveyor asked her about the CHHA and HA, the RCCN stated, "[The] CHHA don't do direct care. CHHAs are HAs, [they] are buddied up with CNAs as long as they are in [the] facility. The TNAs are called HAs [and] should not be doing direct care."

During an interview on 6/5/2023 at 6:32 p.m., CNA #1 stated, "I'm working with the NA (HA #2). She passes trays and answers the call light. I only do care, not the NA. I'm with her the whole shift."

During an interview on 6/5/2023 at 6:35 p.m., when the Surveyor asked the NA (HA #2) her job title, she replied, "CNA."

In the same interview, when the Surveyor asked the NA (HA #2) about the care provided, she replied, "Yes, I provided direct care. I work by myself." Then she walked away. This Surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 85	F 728		

observed HA #2 answer the call light and provided the Resident with ice.

During an interview on 6/5/2023 at 6:53 p.m., when the Surveyor asked about the AS sheet, the Licensed Practice Nurse (LPN #1) stated CNA #1 was not on the schedule; she came to help.

During an interview on 6/5/2023 at 6:55 p.m., the DON stated another CNA did not come into work with HA #2, so CNA #1 came from another floor to help.

During a second interview on 6/5/2023 at 6:58 p.m., LPN #1 stated, "[The] CHHA is not supposed to provide direct care. I just go by the assignment sheet; if it says CNA Assignment, they are CNAs. I don't know why the facility hires CHHAs; I'm not involved with hiring. I didn't know HA #2 was a CHHA until the DON said it. [she is] on Assignment as CNA."

On 6/5/2023 at 12:30 p.m., the Administrator provided the Surveyor with copies of the 2 Department of Health (DOH) Memos dated May 12, 2023.

A review of the first DOH Memo dated May 12, 2023, Under "To:" "Administrators of Long-Term Care Facilities Licensed Pursuant to NJAC 8:39", Under "Subject:" revealed "[redacted] Temporary Feeding Assistant Training Revoked" included: information during the COVID-19 pandemic, about Temporary Feeding Assistants completing a one-hour online training course, passing a [an] online written test and working as a Temporary Feeding Assistant under supervision, [the] waiver will be rescinded 90 days from May 15, 2023 (August 13, 2023) ..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 86	F 728		

A review of a second DOH Memo dated May 12, 2023, Under "To:" "Licensed Inpatient Facility Administrators," Under "Subject:" revealed "03-13-20 Temporary Operational Waivers during a State of Emergency Revoked" included: information during the COVID-19 pandemic .... the waiver applied to exceeding licensed bed capacity, bed additions .... staff qualification requirements .... waiver will be rescinded 90 days from May 15, 2023) August 13, 2023) ...."

On 6/5/2023 at 7:52 p.m., the Surveyors provided a DOH Memo dated April 21, 2023, to the Administrator revealed Under "To:" "Nursing Homes ..." included: "Re: (Reference)" "Temporary Nurse Aides (T.N.A.s) and the Public Health Emergency (P.H.E.) is expected to end on May 11, 2023."

During a telephone interview on 6/6/2023 at 12:33 p.m., the Medical Director (MD) stated she was unaware that uncertified aides, CHHAs, and HAs have been providing care." She continued, "I knew the State gave [the] facility permission to use CHHA to provide assistance, but not hands-on care. It's very important for CNAs to be certified and trained to take care of the patient [Resident]; if not could result in mishaps and injury."

In the same interview, when the Surveyor asked her about her expectation, the MD replied, "The aides are to be certified, have ongoing education and training, renew their licenses, and be allowed to work in the facility."

During an interview on 6/6/2023 at 11:07 a.m., the RN stated, "The nurse ensures the NAs or HAs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 87	F 728		

are not doing direct care. NAs/[CHHAs]/HAs do answer the call light and get water. They can go into the patient's [Resident's] room, see what he/she needs, and tell the aide [CNA]."

During an interview on 6/6/2023 at 11:40 a.m., LPN #2 stated, "Whatever nurse arrives on the floor first does the Assignment. When the Surveyor asked her what duties can the TNA/NA/HA allowed to do, LPN #2 replied, "They are not to assist the Resident with the chuck pad on the bed, not to reposition or move the resident ... TNAs can bring water and supplies ..."

During a telephone interview on 6/6/2023 at 12:30 p.m., when the Surveyor asked her about the HAs, the UM/RN stated, "I assumed when the CNA/aide came to the floor [he/she] was a CNA." She continued, "HA pass out water, deliver trays, make the bed, change the linens, provide water/ice, do simple tasks. [A] HA cannot physically move patients [residents], cannot assist CNA, even if present in the room, they observe, cannot touch [the] patient [Resident]."

During an interview on 6/6/2023 at 2:09 p.m., the RHRM stated, "The Hospitality Aide is the same job description as the Hospitality Liaison."

During an interview on 6/6/2023 at 3:45 p.m., CNA #1 stated, "The HA (HA #2) is [to] observe me, and I answer [their] questions. The NA (HA #2) is not supposed to touch [the] patient [Resident] or move his/her leg, or turn him/her. When the Surveyor asked her what happened with the NA (HA #2) during the care of Resident #7, she replied, "I spoke to her after and [told her] she was supposed to watch me."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 728	Continued From page 88 A review of the updated facility policy titled "Employee Care Partner Hiring Policy" revealed the following: Under "Our Purpose," included "As a caring community, we believe in creating empowered care partner teams who will support our communities in creating meaningful relationships with all people who live and work in the homes. We will hire qualified candidates whose values and attitudes align with our core value of promoting honor, dignity, and respect for all care partners in the homes." Under "Our Strategies" included"...5.All candidates must complete and sign a job application form. 6. The following criteria will be considered in determining whether an applicant is qualified for a particular job position: a. Ability to perform the essential functions of the job ...c. Valid certifications and licenses. 7. Nursing Positions: Department Head, Nursing Services Mentor (Director of Nursing), and Community Mentor (Administrator) will interview candidates and discuss qualifications for potential hire ...22. All policies, procedures, benefits, and conditions of employment must be reviewed with all new hires. All policies and procedures must be signed and dated by the new hire ..."	F 728		
F 835 SS=L	N.J.A.C. 8:39-43.1 N.J.A.C. 8:39-43.2 Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest	F 835		6/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 89 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ164590 Based on observations, interviews, medical records review, and review of other pertinent facility documentation on 6/5/2023, 6/6/2023, and 6/7/2023, it was determined that the facility failed to ensure a process was in place and followed to ensure untrained staff without sufficient competencies were meeting the health and/or safety needs of one or more residents. Hospitality Aides (HAs), which include (Certified Home Health Aides-CHHAs and Temporary Nurses' Aides-TNAs), were competent to provide Resident care by failing to ensure: a.) HAs were enrolled in a State-approved training and competency program, and b.) a system was in place to ensure all HAs received the appropriate training and were deemed eligible to provide resident care, which included, but was not limited to, assisting residents with toilet care, bathing and turning and repositioning residents. On 6/5/2023 at 11:28 a.m., the Surveyor observed an HA (HA #1) assist a resident (Resident #2) from the bathroom with his/her [redacted] and then transferred the Resident from a [redacted] into a chair in the corner of the room. During an interview on 6/5/2023 at 11:29 a.m., the HA said she had 18 residents today, all total care, and she does the same duties as the Certified Nursing Assistant (C.N.A.). On 6/5/2023 at 6:42 p.m., the Surveyor observed HA #2 assisted CNA #1 with bathing when she helped reposition a resident (Resident #7) in bed. The Administrator	F 835	I. - Hospitality Aide (HA) #1, HA #2, HA #3, HA #4, HA #5, HA #6, HA #7, HA #8, HA #9, HA #10, HA #11, HA #12, HA #13; HA #14; HA #15 removed from the facility on 6/7/23 and as of 6/12/23 all were terminated from employment at Merwick; before facility received 2567 report. -HR/Facility Educator immediately, on 6/5/23, completed audit of all hired Certified Home Health Aides (CHHA) for passed criminal background, completed facility orientation program and facility competencies. - On 6/5/23, a revised facility orientation program was in place and followed as per facility policies and procedures, State and Federal regulations. Nursing orientation/clinical validation competencies were in place. -HR/Designee generated a list of all current/newly hired facility employees; the list was pulled from the ADP payroll system immediately, on 6/5/23. -HR/Staffing Coordinator immediately audited all licensed CNAs for having a valid license; all CNAs were in compliance and having active license. -HR/Designee immediately, on 6/5/23, audited all staff assigned to the nursing department to separate CNA licensed from non-licensed to generate a list of the Hospitality Aides (HA). -On 6/5/23, HR/Facility Educator separated all HAs to ones with CHHA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 90 failed to ensure the facility policy titled "Employee Care Partner Hiring Policy" and the job description titled "Administrator" were followed. The facility's failure to have a system in place to ensure that HAs were appropriately trained and certified to provide resident care placed all residents at risk for the likelihood that serious injury, serious harm, and death may occur, resulting in an Immediate Jeopardy situation (IJ). This placed all residents in an IJ situation. The IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (D.O.N.) on 6/5/2023 at 8:00 p.m. The Administrator was presented with the IJ template that included information about the issue. The IJ began on 6/5/2023 and continued through 6/7/2023, when the facility removed all HAs from the floor. On 6/7/2023, the Removal Plan was implemented. The facility implemented the Removal Plan, which included removing all uncertified aides [H.A.s] from the floor and educating all staff that uncertified aides [H.A.s] are not to be in resident care areas. So, the noncompliance remained on 06/7/2023 as a level F for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. This deficient practice was identified for 15 Hospitality Aides (H.A.s) reviewed that provided care on 4 of 4 resident units from 5/11/2023 through 6/5/2023 and was evidenced by the following: On 6/5/2023 at 10:37 a.m., the Surveyor took a tour of the [redacted]-floor unit and requested the	F 835	license and non-licensed ones. Out of 10 Hospitality Aides 7 had active CHHA license. Out of 10 newly hired Hospitality Aids 4 completed general orientation and clinical competency validation program. -On 6/5/23, a revised facility general orientation program as well as nursing orientation/training program was in place. All newly hired employees, including RNs, LPNs, CNAs , and HAs were required to complete the facility orientation program. All nursing, in addition to the general orientation, must complete nursing orientation, including clinical validation competencies training. -On 6/5/23, all HAs re-in-serviced on hospitality aide scope of services as per the facility policies and procedures, State and Federal regulations immediately. -On 6/5/23, HR ensured that all facility policies and procedures in hiring process were followed to make sure that all forms completed and all required documents collected/verified/signed. -On 6/5/23, HR/Designee immediately completed audit of current nursing employees' files for completion of the hiring process, including signing the job description and having valid licenses. -On 6/5/23, HR/Facility Educator continued following facility hiring process and general facility orientation for newly hired employees; all newly hired nursing staff, including RNs, LPNs, CNAs , and HAs were completing nursing orientation and all required clinical validation competencies. -On 6/5/23, DON/Designee audited all Risk Management reports to identify if any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 91 Assignment Sheet (AS) for the 7:00 a.m. - 3:00 p.m. shift. The AS revealed the unit "3 CNA Assignment" with 3 names listed for each of the 3 hallways on the unit, including HA #1 with her own Assignment of 17 residents. At 6:23 p.m., the Surveyor took a [redacted] tour of the unit and requested the AS for the 3:00 p.m.-11:00 p.m. shift for the "3 CNA Assignment," revealing 3 CNA names per hallway, to include HA #2 with her own Assignment of 20 residents. On 6/5/2023 at 11:28 a.m., the Surveyor observed HA #1, as noted on her employee badge, provide assistance to a Resident (Resident #2) walking from the bathroom with his/her walker across the room and provided transfer assistance from a standing position into a sitting position to a chair in the corner of the room. On 6/5/2023 at 6:42 p.m., the Surveyor observed HA #2 assisted CNA #1 with bathing when she helped reposition a resident (Resident #7) in bed. HA #2 was observed helping CNA #1 reposition the Resident up in bed by assisting with the chuck pad (sheet located under the Resident to help with movement) to move the Resident towards the head of the bed and also helped reposition his/her right leg during bathing. During an interview on 6/5/2023 at 4:50 p.m., the Administrator stated, "The TNAs were already hired when I started; TNAs were to complete 8 hours of training, online training, and basically processes here were not in place." In the same interview, when the Surveyor asked about the TNAs providing care, the Administrator stated, "I believe not, "the TNA needs to do 80	F 835	non-licensed nursing staff were involved. Summary/description of event will be provided to include any evidence that led to a serious adverse outcome if any non-licensed nursing staff were involved in any incident events. As per completed audit, none of the Hospitality Aides were involved in any facility resident incidents. - On 6/7/23 at 4:20PM, all Hospitality Aides (HAs), who were Certified Home Health Aides as well, were off the floor. All HAs were not to be in the residents' care areas. - On 6/7/23, all HAs were removed/discharged from the facility and by 6/12/23 - all HAs were terminated from Merwick Care and Rehabilitation Center employment. -Results of the audits and findings, if any, will be presented to the monthly QAPI meetings for review and revised as deemed appropriate. - On 6/7/23, full audit of all non-certified staff vs facility incident reports was completed as following: a. Timecards of all non-certified employees printed, starting from the date of hire of each employee. b. All facility incidents were printed starting from 2/4/2022 - the date of hire of the longest staying employee. c. All facility incidents were cross checked against all time cards of each employee to rule out any involvement of the non-certified employees in any facility incidents. d. All data was recorded in the Risk Management Reports of Incidents vs Staff Involvement tracking tool.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 92 hours of training of [per the] state regulation, and the "TNA shadows a CNA." In the same interview, when the Surveyor asked about the duties of the HAs and Certified Home Health Aides (CHHAs), the Administrator stated, "HAs don't provide care, only ice water, and I need to check if a HA can assist a resident to the bathroom, I think a certified person, a nurse or CNA [is] to do care. CHHA and HA are the same. CHHA is a HA. CHHA have [their] own license but don't provide care. NA (Nursing Aides) don't have skills, [so] I let them go [from employment]. If the NAs could not provide [the] course online, we [facility] created hospitality aides (HAs), we're awaiting [CNA] classes to be provided, I'd rather have some people to answer the call bell, get [a] glass of water. [The] HA would cover this, [be] a help on the floor w/CNAs and nurses." In a second interview on 6/5/2023 at 5:35 p.m., when the Surveyor asked the Administrator who ensures the TNA and HA receive the required training, the Administrator replied the Nursing Staff Educator (NSE). The NSE was unavailable for the months between March and May, so the Regional Corporate Clinical Nurse (RCCN) was responsible. During an interview on 6/5/2023 at 5:40 p.m., the RCCN stated, "The State extended deadlines; I provided education to TNAs on competencies for ADLs. After training, the TNA is buddied up [paired] with a CNA for 2-3 weeks, then after I would do another competency with the UM ...TNAs are used after taking 8 hours [of] class and enrolled in a school, buddied up, doesn't stop until certified. I'm not sure if the TNAs are now enrolled in school; I have to check. Some were	F 835	e. Based on the collected information out of 15 non-certified employees in the list 0 were involved in any resident incidents. - Results of the audit was provided to the DOH Survey team. II. - All residents have the potential to be affected by the same deficient practice. III. - ADON/Designee completed full audit on all employees to ensure completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program. - Facility Educator/Designee ensured that all newly hired licensed nursing staff, including RNs, LPNs, CNAs, in addition to the general orientation, complete nursing orientation, including clinical validation competencies training immediately. - Facility Educator/Designee will continue to facilitate general orientation for all staff and nursing orientation program for RNs, LPNs, CNAs. - On 6/5/23, Facility Educator/Designee in-serviced all Unit Managers on their responsibilities as per job description, including that each unit manager was responsible for supervising unit's nursing staff, including HAs; Unit Manager was responsible for assuring daily staffing assignments; if Unit Manager was not available, charge nurse would be responsible for the daily assignment. All nursing, including RNs, LPNs, CNAs, and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 93 terminated if not [enrolled] in school. Prior to 2021, [TNA] take[s] [an] 8-hour class and enroll in a CNA program. If they are not able to enroll in CNA school, we will switch them to HA, which will be a buddy system. There's no documentation of a buddy system; it's only on [the] staffing sheets." During an interview on 6/7/2023 at 1:23 p.m., the Administrator stated, "The HA/NA/TNA shadow the CNA, they pass water, answer the call bell and hand them [CNAs] the clothing, I don't know exactly, what [they] do, I need to look at the job description to clarify." During an interview on 6//12/2023 at 11:04 a.m., the NSE stated, "In the past, I don't know what happened. Once the CNA is assigned to another CNA, if lacking competencies, I re-educate, then the CNA can be released to do care." When asked about the HAs, the NSE replied: "No, cannot do care." In the same interview, when the Surveyor asked about the hours needed for required training, the NSE continued to say, "I do not know about the number of hours/modules the CNAs have to complete to become certified. I was not expected to know ..." A review of the undated "Position Title: Administrator" revealed Under "Responsibilities/Accountabilities:" included: " ...Interprets personnel practices within policy guidelines ...is responsible for planning an is countable for all activities and departments subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents; ...Oversees and guides department managers in the development and use of departmental policies and procedures; Review and evaluates the work performance	F 835	HAs, if any, must complete general orientation, clinical validation competencies and orientation to the Unit with Unit Manager/Nursing Supervisor/Charge Nurse. Unit Manager performs all assigned duties, including responsibility for assuring daily staffing assignments based on the job description that they received/signed upon hiring; signage of job description is part of the onboarding during the hiring process; HAs must provide non-direct care on the unit. -On 6/5/23, facility Educator/Designee facilitated training sessions for all nursing/non-nursing staff as per established facility training program. Facility IP/Educator will continue to facilitate established facility training program. -Training sessions on Removal Pans for F 835 started on 6/5/23. Administrator facilitated in-service for the management team and on 6/5/23, Facility Educator/Designee took over to facilitate in-service for all staff. Additional topics presented: a. Facility Direct Care providers, their credentials and responsibilities based on job description and facility policies and procedures. b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any. d. Unit Managers/Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 94 assigned personnel as well as counsel/discipline assigned personnel according to established company personnel policy; ...Implements facility objectives as determined and directed by the governing body; ...Ensures the residents and families receive the highest quality of service in a caring and compassionate atmosphere which recognizes the individuals' needs and rights; ..." A review of the updated facility policy titled "Employee Care Partner Hiring Policy" revealed the following: Under "Our Purpose" included "As a caring community, we believe in creating empowered care partner teams who will support our communities in creating meaningful relationships with all people who live and work in the homes. We will hire qualified candidates whose values and attitudes align with our core value of promoting honor, dignity, and respect for all care partners in the homes." Under "Our Strategies" included " ...5.All candidates must complete and sign a job application form. 6. The following criteria will be considered in determining whether an applicant is qualified for a particular job position: a. Ability to perform the essential functions of the job ...c. Valid certifications and licenses. 7. Nursing Positions: Department Head, Nursing Services Mentor (Director of Nursing), and Community Mentor (Administrator) will interview candidates and discuss qualifications for potential hire ...22. All policies, procedures, benefits, and conditions of employment must be reviewed with all new hires. All policies and procedures must be signed and dated by the new hire ..." N.J.A.C. 8:39-43.1 N.J.A.C. 8:39-43.2	F 835	Supervisors/Charge nurse responsibilities. e. Facility training program for nursing and non-nursing staff. - Facility Educator/Designee will continue in-services on the following topics: a. Facility Direct Care providers, their credentials and responsibilities based on job description and facility policies and procedures. b. Facility general orientation/nursing orientation including clinical competency validations completion. c. HR follows facility policy and procedures on hiring, including completion of all required documentations/orientation paperwork/validation of certification, if any. d. Unit Managers/Nursing Supervisors/Charge nurses' responsibilities. e. Facility training program for nursing and non-nursing staff. - Regional Director of Operations (RDO) in-serviced the facility Licensed Nursing Home Administrator (LNHA) on N.J. Admin. Code 8:39-43.2 regarding requirements for nurse aide certification. and Employee Care Partner Policy. IV. - DON/Designee will continue to conduct random audits for newly hired employees to ensure completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program; audits will be conducted weekly X 4 weeks, bi-weekly X	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. BUILDING _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 835	Continued From page 95	F 835	4 weeks, then monthly for next three months. - DON/Designee will continue to conduct random audits for all newly hired employees to ensure completion of the facility general orientation program; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - DON/Designee will continue to conduct random audits for all newly hired nursing staff, including RNs, LPNs, CNAs to ensure, in addition to the general orientation, completion of nursing orientation, including clinical validation competencies and mandatory trainings; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Administrator/Designee will conduct spot audits on completion of all required documentations/orientation paperwork/validation of certification, if any, and to ensure that all newly hired employees complete the facility orientation program as well as all newly hired nursing staff complete nursing orientation, including clinical validation competencies and mandatory trainings; audits will be conducted weekly X 4 weeks, bi-weekly X 4 weeks, then monthly for next three months. - Results of the audits 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
	11103L	A. BUILDING: _____ B. WING _____	C 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments COMPLAINT#: NJ155672, NJ159535, NJ161374, NJ161777, NJ163444, NJ163448, NJ163626, NJ164589, NJ164590 CENSUS: 148 SAMPLE SIZE: 14 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ155672, NJ159535, NJ161374, NJ161777, NJ163444, NJ163448, NJ163626, NJ164589, NJ164590 Based on facility document review on 6/5/2023, 6/6/2023, 6/7/2023, 6/8/2023, 6/9/2023 and 6/12/2023, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident	S 560	I. - Corporate Recruiter (CP) hired to assist the facility in hiring candidates for open licensed nursing positions; CP is responsible for attracting the candidates through various channels like official job search engines, social media and professional networks; for finding and screening candidates; scheduling	7/19/23

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 ratios as mandated by the State of New Jersey Certified Nurse's Aides (CNAs). This deficient practice had the potential to affect all residents. Findings include: 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 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as 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: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of complaint staffing from 06/12/2022 to 06/25/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -06/12/22 had 11 CNAs for 155 residents on the day shift, required 19 CNAs. -06/13/22 had 13 CNAs for 153 residents on the day shift, required 19 CNAs. -06/14/22 had 14 CNAs for 153 residents on the	S 560	interviews by coordinating with candidates and hiring managers; organizing facility job fairs. - Facility will identify/meet with representative(s) from two Certified Nursing Assistant/LPN vocational schools in the area to establish collaborative relationships to recrute graduated CNAs with further job placement at the facility. - Facility opened additional facility Indeed Account to advertise all in-house nursing openings, including Certified Nursing Assistant (CNA) positions. - Facility implemented weekly incentive bonus structure to increase overall CNA's rate to the competitive market level. - Facility implemented aggressive advertisement of the open nursing positions, including job fairs with immediate interviews and contingency offers for all licensed nursing staff, including CNAs. - Facility implemented shift differential pay structure for 3-11 and 11-7 shifts. - Facility implemented signed-on bonus for the CNAs to attract and retain candidates. II. - All residents have the potential to be affected by the deficient practice. III. - - Facility Master Schedule is in place and updated real time to match with ADP payroll system; each CNA has ADP app on the phone to be aware of the scheduled shifts to comply with attendance for scheduled working hours. - Facility will continue to hire Per Diem	

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 day shift, required 19 CNAs. -06/15/22 had 16 CNAs for 153 residents on the day shift, required 19 CNAs. -06/16/22 had 14 CNAs for 153 residents on the day shift, required 19 CNAs. -06/17/22 had 15 CNAs for 155 residents on the day shift, required 19 CNAs. -06/17/22 had 10 total staff for 155 residents on the overnight shift, required 11 total staff. -06/18/22 had 12 CNAs for 155 residents on the day shift, required 19 CNAs. -06/18/22 had 9 total staff for 155 residents on the overnight shift, required 11 total staff. -06/19/22 had 10 CNAs for 154 residents on the day shift, required 19 CNAs. -06/20/22 had 13 CNAs for 151 residents on the day shift, required 19 CNAs. -06/21/22 had 11 CNAs for 151 residents on the day shift, required 19 CNAs. -06/22/22 had 12 CNAs for 151 residents on the day shift, required 19 CNAs. -06/23/22 had 12 CNAs for 151 residents on the day shift, required 19 CNAs. -06/24/22 had 10 CNAs for 150 residents on the day shift, required 19 CNAs. -06/25/22 had 11 CNAs for 150 residents on the day shift, required 19 CNAs. 2. For the 2 weeks of complaint staffing from 11/06/2022 to 11/19/2022, the facility was deficient in CNA staffing on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -11/06/22 had 11 CNAs for 144 residents on the day shift, required 18 CNAs. -11/07/22 had 12 CNAs for 144 residents on the day shift, required 18 CNAs.	S 560	licensed nursing staff to cover the shifts in any case of call outs. - Administrator, Director of Nursing and Staffing Coordinator are meeting every morning to discuss staffing schedule for the day and following 3-5 days. - Facility has 24-hour nursing management on-call rotation in case of any call outs and/or to cover the floor if needed. - Facility utilizes reinforcement steps for excessive call outs if any. IV. - DON/Designee will monitor ratios weekly until requirements are met; the results of the audits will be forwarded to the facility Administrator and monthly QAPI Committee for review and revision as deemed appropriate. - The Human Resources Director/Designee will report recruitment and retention trends, outcomes, and recommendations to the Quality Assurance and Performance Improvement Committee meetings monthly x 3 months, then quarterly x 9 months for review and revision as deemed appropriate.	

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 -11/08/22 had 10 CNAs for 144 residents on the day shift, required 18 CNAs. -11/09/22 had 9 CNAs for 144 residents on the day shift, required 18 CNAs. -11/10/22 had 13 CNAs for 144 residents on the day shift, required 18 CNAs. -11/11/22 had 13 CNAs for 141 residents on the day shift, required 18 CNAs. -11/11/22 had 9 total staff for 141 residents on the overnight shift, required 10 total staff. -11/12/22 had 13 CNAs for 141 residents on the day shift, required 18 CNAs. -11/13/22 had 12 CNAs for 141 residents on the day shift, required 18 CNAs. -11/13/22 had 13 total staff for 141 residents on the evening shift, required 14 total staff. -11/14/22 had 13 CNAs for 140 residents on the day shift, required 17 CNAs. -11/15/22 had 14 CNAs for 138 residents on the day shift, required 17 CNAs. -11/16/22 had 13 CNAs for 138 residents on the day shift, required 17 CNAs. -11/17/22 had 15 CNAs for 138 residents on the day shift, required 17 CNAs. -11/18/22 had 14 CNAs for 138 residents on the day shift, required 17 CNAs. -11/19/22 had 11 CNAs for 138 residents on the day shift, required 17 CNAs. 3. For the 2 weeks of staffing from 02/05/2023 to 02/18/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -02/05/23 had 13 CNAs for 159 residents on the day shift, required 20 CNAs. -02/06/23 had 13 CNAs for 159 residents on the	S 560		

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4	S 560		

day shift, required 20 CNAs.
-02/06/23 had 10 total staff for 159 residents on the overnight shift, required 11 total staff.
-02/07/23 had 16 CNAs for 159 residents on the day shift, required 20 CNAs.
-02/08/23 had 16 CNAs for 159 residents on the day shift, required 20 CNAs.
-02/09/23 had 15 CNAs for 164 residents on the day shift, required 20 CNAs.
-02/10/23 had 13 CNAs for 164 residents on the day shift, required 20 CNAs.
-02/11/23 had 13 CNAs for 164 residents on the day shift, required 20 CNAs.

-02/12/23 had 14 CNAs for 165 residents on the day shift, required 21 CNAs.
-02/12/23 had 14 total staff for 165 residents on the evening shift, required 17 total staff.
-02/13/23 had 12 CNAs for 162 residents on the day shift, required 20 CNAs.
-02/14/23 had 16 CNAs for 162 residents on the day shift, required 20 CNAs.
-02/14/23 had 11 total staff for 162 residents on the overnight shift, required 12 total staff.
-02/15/23 had 18 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/16/23 had 15 CNAs for 161 residents on the day shift, required 20 CNAs.
-02/17/23 had 13 CNAs for 160 residents on the day shift, required 20 CNAs.
-02/18/23 had 14 CNAs for 158 residents on the day shift, required 20 CNAs.

4. For the 3 weeks of complaint staffing from 03/12/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on 21 of 21 day shifts, deficient in total staff for residents on 1 of 21 evening shifts, deficient in CNAs to total staff on 2 of 21 evening shifts, and deficient in total staff for residents on 1 of 21 overnight shifts

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 as follows: -03/12/23 had 11 CNAs for 151 residents on the day shift, required 19 CNAs. -03/13/23 had 11 CNAs for 150 residents on the day shift, required 19 CNAs. -03/14/23 had 12 CNAs for 150 residents on the day shift, required 19 CNAs. -03/15/23 had 14 CNAs for 150 residents on the day shift, required 19 CNAs. -03/16/23 had 11 CNAs for 150 residents on the day shift, required 19 CNAs. -03/17/23 had 9 CNAs for 154 residents on the day shift, required 19 CNAs. -03/18/23 had 13 CNAs for 154 residents on the day shift, required 19 CNAs. -03/19/23 had 10 CNAs for 154 residents on the day shift, required 19 CNAs. -03/19/23 had 9 CNAs to 20 total staff on the evening shift, required 10 CNAs. -03/20/23 had 12 CNAs for 149 residents on the day shift, required 19 CNAs. -03/21/23 had 14 CNAs for 149 residents on the day shift, required 19 CNAs. -03/22/23 had 17 CNAs for 149 residents on the day shift, required 19 CNAs. -03/23/23 had 15 CNAs for 149 residents on the day shift, required 19 CNAs. -03/24/23 had 15 CNAs for 149 residents on the day shift, required 19 CNAs. -03/25/23 had 16 CNAs for 151 residents on the day shift, required 19 CNAs. -03/26/23 had 12 CNAs for 150 residents on the day shift, required 19 CNAs. -03/26/23 had 14 total staff for 150 residents on the evening shift, required 15 total staff. -03/27/23 had 12 CNAs for 150 residents on the day shift, required 19 CNAs.	S 560		

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 6 -03/28/23 had 10 CNAs for 150 residents on the day shift, required 19 CNAs. -03/29/23 had 18 CNAs for 150 residents on the day shift, required 19 CNAs. -03/30/23 had 17 CNAs for 156 residents on the day shift, required 19 CNAs. -03/31/23 had 13 CNAs for 155 residents on the day shift, required 19 CNAs. -04/01/23 had 12 CNAs for 154 residents on the day shift, required 19 CNAs. -04/01/23 had 8 CNAs to 19 total staff on the evening shift, required 10 CNAs. 5. For the 2 weeks of complaint staffing from 04/09/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -04/09/23 had 8 CNAs for 152 residents on the day shift, required 19 CNAs. -04/10/23 had 11 CNAs for 152 residents on the day shift, required 19 CNAs. -04/10/23 had 10 total staff for 152 residents on the overnight shift, required 11 total staff. -04/12/23 had 14 CNAs for 152 residents on the day shift, required 19 CNAs. -04/13/23 had 14 CNAs for 158 residents on the day shift, required 20 CNAs. -04/14/23 had 12 CNAs for 158 residents on the day shift, required 20 CNAs. -04/15/23 had 13 CNAs for 158 residents on the day shift, required 20 CNAs. -04/15/23 had 8 CNAs to 18 total staff on the evening shift, required 9 CNAs. -04/16/23 had 12 CNAs for 156 residents on the day shift, required 19 CNAs. -04/17/23 had 12 CNAs for 156 residents on the	S 560		

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 7 day shift, required 19 CNAs. -04/18/23 had 14 CNAs for 157 residents on the day shift, required 20 CNAs. -04/19/23 had 14 CNAs for 156 residents on the day shift, required 19 CNAs. -04/20/23 had 15 CNAs for 156 residents on the day shift, required 19 CNAs. -04/21/23 had 14 CNAs for 155 residents on the day shift, required 19 CNAs. -04/21/23 had 10 total staff for 155 residents on the overnight shift, required 11 total staff. -04/22/23 had 11 CNAs for 155 residents on the day shift, required 19 CNAs. 6. For the 3 weeks of complaint staffing from 04/30/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 19 of 21 day shifts as follows: -04/30/23 had 15 CNAs for 157 residents on the day shift, required 20 CNAs. -05/01/23 had 17 CNAs for 157 residents on the day shift, required 20 CNAs. -05/03/23 had 17 CNAs for 157 residents on the day shift, required 20 CNAs. -05/05/23 had 18 CNAs for 161 residents on the day shift, required 20 CNAs. -05/06/23 had 16 CNAs for 161 residents on the day shift, required 20 CNAs. -05/07/23 had 13 CNAs for 161 residents on the day shift, required 20 CNAs. -05/08/23 had 16 CNAs for 161 residents on the day shift, required 20 CNAs. -05/09/23 had 17 CNAs for 161 residents on the day shift, required 20 CNAs. -05/10/23 had 16 CNAs for 161 residents on the day shift, required 20 CNAs. -05/11/23 had 18 CNAs for 161 residents on the day shift, required 20 CNAs.	S 560		

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 8 -05/12/23 had 15 CNAs for 160 residents on the day shift, required 20 CNAs. -05/13/23 had 10 CNAs for 159 residents on the day shift, required 20 CNAs. -05/14/23 had 10 CNAs for 156 residents on the day shift, required 19 CNAs. -05/15/23 had 13 CNAs for 155 residents on the day shift, required 19 CNAs. -05/16/23 had 18 CNAs for 154 residents on the day shift, required 19 CNAs. -05/17/23 had 15 CNAs for 154 residents on the day shift, required 19 CNAs. -05/18/23 had 16 CNAs for 154 residents on the day shift, required 19 CNAs. -05/19/23 had 17 CNAs for 154 residents on the day shift, required 19 CNAs. -05/20/23 had 12 CNAs for 163 residents on the day shift, required 20 CNAs. 7. For the 2 weeks of staffing prior to survey from 05/21/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -05/21/23 had 11 CNAs for 162 residents on the day shift, required 20 CNAs. -05/22/23 had 14 CNAs for 160 residents on the day shift, required 20 CNAs. -05/23/23 had 16 CNAs for 160 residents on the day shift, required 20 CNAs. -05/24/23 had 13 CNAs for 160 residents on the day shift, required 20 CNAs. -05/25/23 had 17 CNAs for 158 residents on the day shift, required 20 CNAs. -05/26/23 had 17 CNAs for 158 residents on the day shift, required 20 CNAs. -05/27/23 had 17 CNAs for 155 residents on the day shift, required 19 CNAs.	S 560		

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 06/12/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 9 -05/28/23 had 12 CNAs for 155 residents on the day shift, required 19 CNAs. -05/29/23 had 17 CNAs for 155 residents on the day shift, required 19 CNAs. -05/30/23 had 16 CNAs for 154 residents on the day shift, required 19 CNAs. -05/31/23 had 14 CNAs for 154 residents on the day shift, required 19 CNAs. -06/01/23 had 18 CNAs for 154 residents on the day shift, required 19 CNAs. -06/02/23 had 16 CNAs for 154 residents on the day shift, required 19 CNAs. -06/03/23 had 11 CNAs for 154 residents on the day shift, required 19 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
11103L Y1	A. Building B. Wing Y2	7/19/2023 Y3

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

This report is completed by a 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	07/19/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
6/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315001 Y1	A. Building B. Wing Y2	7/19/2023 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0657	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed
LSC	06/18/2023	LSC	06/18/2023	LSC	06/18/2023
ID Prefix F0686	Correction	ID Prefix F0692	Correction	ID Prefix F0697	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.25(k)	Completed
LSC	06/13/2023	LSC	06/13/2023	LSC	06/13/2023
ID Prefix F0726	Correction	ID Prefix F0728	Correction	ID Prefix F0835	Correction
Reg. # 483.35(a)(3)(4)(c)	Completed	Reg. # 483.35(d)(1)-(3)	Completed	Reg. # 483.70	Completed
LSC	06/18/2023	LSC	06/13/2023	LSC	06/13/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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?
6/12/2023	☐ YES ☐ NO