STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

(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
F0000	INITIAL COMMENTS A Recertification survey was conducted by Healthcare Management Solutions, LLC on behalf of New Jersey Department of Health (NJDOH). Complaint: 2703693 Survey Dates: 01/12/26-01/15/26. Survey Census: 84 Sample Size: 27 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 RECERTIFICATION VISIT.	F0000		02/17/2026
F0755 SS = F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F0755	1- Every medication (narcotic and non-narcotic) blister pack in the facility was reviewed between 1/16/2026 and 1/20/2026 by the Licensed Nurse Unit Managers, Licensed Nurse Infection Preventionist and the Director of Nursing and it was noted that every medication blister pack reflected a method for the licensed nurse to follow the five medication rights by clearly stating "Resident Name", "Medication Name and strength" and "See MD Orders" to ensure that there is minimal risk of drug diversion, theft, improper handling of returns that impact patient safety and compliance. [redacted] was given one on one in service by the Director of Nursing on 1/16/2026 about the five rights of medications are followed during medication administration. Facility Administrator reviewed our current procedures with the Facility Pharmacy provider in implementing new labeling processes for medications, including controlled substances, to include the medication administration directions for use in accordance with the physician orders.	04/14/2026

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 reverse for further 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.

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

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F0755 SS = F	Continued from page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interviews, and facility policy review the facility failed to implement pharmacy processes for labeling medications, including controlled substances (CS), for four of four medication carts (Medication Carts One and Two on [redacted] Unit; Medication Carts One and Two on [redacted] Unit) observed for medication storage and labeling of 27 sample residents. This failure had the potential risk of drug diversion, theft, improper handling of returns, all impacting patient safety and compliance. Findings include: During observation of medication cart one on the [redacted] Hall on 01/13/26 at 1:00 PM, Licensed Practical Nurse (LPN) 2 revealed routine and controlled medications blister pack labels and controlled substance inventory log sheets located in medication cart one, which reflected "See [redacted] orders" as medication administration directions for use in accordance with the physician's orders. During an interview on 01/13/26 at 1:15 PM, LPN2 said that the nurses who received the medications including controlled substances, from the pharmacy, were responsible for ensuring the resident's name, prescribing doctor, directions for medication administration, the Rx (prescription) number, the name of the issuing pharmacy, and the Rx issue date reflected on the medication blister pack(s) label and on the narcotic inventory sheet. LPN2 said that the [redacted] also checked the medication labels and narcotic inventory sheets when on-site to conduct a medication cart audit. LPN2 said that "See [redacted] orders" was not an actual direction for use, but a reference to the resident's medication administration record (MAR) for specific instructions. During observation of medication cart two on [redacted]	F0755	Continued from page 1 2- All residents have the potential to be affected by the cited practice. 3- Facility will continue to review with our contracted pharmacy provider to ensure the current NJ State and Federal labeling regulations are followed. Facility has the contracted consultant pharmacist review the labeling when completing the monthly medication storage and labeling reviews to confirm provider pharmacy complied as noted with both the NJ State and Federal regulations. An in service was started on 2/2/2026 and is ongoing by the Director of Nursing for licensed nurses to ensure that the five rights of medications: Right Patient, Right Dose, Right Route, Right Time and Right Route are followed. This in service will be given annually, upon new hire of license nurse and as needed. An in-service was started on 4/14/26 by the Director of Nursing and is ongoing to license nurses about the pharmacy provider's new medication labeling processes, including controlled substances, to include the medication administration directions for use in accordance with the physician orders. The facility policy for Medication Label was reviewed on 4/14/26 by the facility administrator and was revised to reflect the new medication labeling processes. 4- Director of Nursing or license nurse designee will audit the Medication pharmacy labeling including controlled substance medications to ensure that the medication label reflects the medication administration direction for use in accordance with the physician order for 6 residents weekly covering all 4 medication carts x 1 month and then x 3 months. Any discrepancies will be corrected by the director of nursing or nurse supervisor The facility contracted consultant pharmacist will perform an audit of 10 resident medications during their monthly visit to ensure that proper labeling of medications provided by the facility provider pharmacy complied in accordance with the NJ State and Federal labeling regulations as well as facility new policy. Any negative findings will be corrected and reported to the DON immediately.	04/14/2026

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F0755 SS = F	Continued from page 2 Hall on 01/13/26 at 3:45 PM, Registered Nurse (RN) 2 revealed routine and controlled medications blister pack labels and controlled substance inventory log sheets located in medication cart two, which reflected "See [redacted] Orders" as medication administration directions for use in accordance with the physician's orders. During an interview on 01/13/26 at 3:59 PM, RN2 said he/she reviewed the MAR for instructions to administer medications to the resident. RN2 said that "See [redacted] Orders" printed as the instructions for use did not follow the medication rights for verification to check the medication label against the order in the MAR before giving to the resident. RN2 stated not verifying the medication label against the physician's order could potentially risk patient safety. RN2 said that controlled substances could be miscounted or incidents of drug diversion when the medication blister pack did not reflect the number of pills that should be administered. During random observations of medication cart one on 01/14/26 at 8:30 AM with LPN1 and medication cart two at 8:40 AM with the [redacted] on the [redacted] Hall revealed routine and controlled medications blister pack labels and controlled substance inventory log sheets, reflected "See [redacted] Orders" as medication administration directions for use in accordance with the physician's orders. During an interview on 01/14/26 at 10:04 AM, the [redacted] stated that "See [redacted] Orders," was a process throughout the facility to prevent the need for clarification or to question orders with the physician. He/she said that the physician's wrote orders in the hard chart and any clarification of orders would be done before entered into the electronic medical record (EMR). The [redacted] said that he/she checked the EMR after a new admit ensuring orders were entered correctly and matched the discharge orders. The [redacted] said that he/she periodically checked physician orders in the EMR that they were entered correctly. During a phone interview on 01/15/26 at 9:45 AM, the [redacted] said that he/she conducted medication cart audits at the facility to systematically check for regulatory compliance including proper labeling that aligned with the MARs/orders, which was essential for patient safety. The [redacted] said that audits confirmed adherence to policies, identified system failures, provided education, and prevented errors with high-risk meds. The [redacted] said that pharmacies in	F0755	Continued from page 2 Results of the audits will be submitted to the Quality Assessment and Assurance Committee (QAA) for review and recommendations during quarterly meetings and will decide the necessity for further audits.	04/14/2026

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F0755 SS = F	Continued from page 3 the State of New Jersey were not required to write out the instructions for use on the label of the drug card and that "See U.S. FO Orders" was appropriate. During an interview on 01/15/26 at 12:16 PM, the U.S. FOIA (b)(6)) said that the nurses and U.S. FOIA (b)(6) were responsible for overseeing procedures that prevented medication errors and drug diversion such as performing the medication rights, ensuring the medication label and MAR matched, in that it was the right medication, right dose, right form, given at the right time, to the right resident via the right route. The U.S. FOIA said that the pharmacy consultant also audited the medication carts every two to three months to ensure that the facility complied with policies and procedures. The U.S. FOIA (b) said that the label instructed the nurse to "See U.S. FO Orders" and the MAR would indicate how to administer the medication. Review of the facility's policy titled, "LTC [Long Term Care] Pharmacy Services," revised 06/19/23, provided by the DON, indicated, "PURPOSE To ensure that all medications are properly labeled. … POLICY All medications dispensed or stored in the pharmacy must be labeled as per procedure. … PROCEDURE Medications dispensed to residents are appropriately and safely labeled. … Any labeling that is consistent with law, regulation and professional practice Intravenous (IV) medication labels shall have labels that bear: The Resident's full name; The prescriber's name; The prescription number; The name and strength of drug; The quantity dispensed; The lot number; The date of Issue; The expiration date; The manufacturer's name if generic; Cautionary and/or accessory labels; Directions for use …" NJAC 8:39-5.1(a) NJAC 8:39-29.1 NJAC 8:39-29.4	F0755		04/14/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local	F0812	On 1/12/26 the dietary staff cleaned the tile wall and floor behind and underneath the dishwasher. On 1/12/26 the dietary staff cleaned the surface and undercarriage of the heating unit. On 1/15/26 the dietary staff cleaned the legs of the steam table and food prep table and shelves with an electric scrub brush and the debris came off.	02/17/2026

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F0812 SS = F	Continued from page 4 authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and policy review, the facility failed to prevent the build-up of grease, food crumbs, and dirt on fixed equipment, behind cooking equipment and on walls and floors for one of one kitchen, as well as failing to clean and maintain two of three ice machines in the facility. This deficient practice had the potential to affect 84 of 84 residents who received meals and beverages prepared in and served from the facility's kitchen and pantries. Findings include: 1.During the initial kitchen tour and observation on 01/12/26 at 9:58 AM, the dishwasher revealed the tile wall and floor behind and underneath the dishwasher, covered in dark blackish-brown debris consisting of grease, food debris and dust and dirt. The debris was observed covering the surface and undercarriage of the heating unit. The observation also revealed the dark blackish-brown debris on the legs of the steam table, food preparation tables and shelves, and build-up of grease and residue on the outside of the gas range and the double ovens. During an interview on 01/12/26 at 10:03 AM, the U.S. FOIA (b)(6) was asked about the soiled surfaces behind and under the dishwasher and peripheral equipment, and he/she advised that they tried to clean them daily. During observations on 01/14/26 at 10:51 AM and on 01/15/26 at 8:35 AM, the range, double ovens, steam table, and preparation surface areas behind and beneath the equipment remained soiled.	F0812	Continued from page 4 On 1/15/26 the dietary staff cleaned the outside of the gas range and double oven with an electric scrub brush and the grease and residue were removed. On 1/15/26 the Housekeeping Director cleaned the inside and outside of the ice machine chute on Sub-Acute and Long-Term units. All residents have the potential to be affected by this deficient practice. Facility Ice Machine Vendor came out on 1/19/26 to professionally clean and sanitize all components including the chute and chute assembly of the ice machines. On 1/15/26 The facility purchased a commercial grade electric scrub brush along with commercial grade stainless steel surface care solutions. All dietary staff were re-educated on 1/15/26 on proper cleaning and sanitization of walls, floors and equipment for debris, residue and grease. U.S. FOIA (b)(6) and U.S. FOIA (b)(6) were re-educated on 1/15/26 on proper cleaning of inside and outside of ice machine chutes. The dietary cleaning schedule was reviewed and revised for cooks and dietary aides to include weekly deep cleaning assignments of all stationary equipment with the electric scrub brush and stainless steel surface care solutions as appropriate. The ice machine cleaning schedule was reviewed and revised for the ice machines to include the inside and outside of the chute. A visual inspection will be conducted by the Facility Administrator or designee along with the Dietary Director monthly x 6 months and then bi-monthly for 6 months to ensure there is no build-up of grease, food crumbs, and dirt on fixed equipment, behind cooking equipment and on walls and floors. A visual inspection will be conducted by the Facility Administrator or designee along with the Maintenance Director monthly x6 months and then bi-monthly x 6months to ensure there is no slimy,	02/17/2026

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F0812 SS = F	Continued from page 5 During an interview on 01/15/26 at 8:35 AM, the U.S. FO was asked about the areas, and he/she stated that they tried to remove the debris with a pressure washer but had not been successful. He/she did, however, reveal that the area behind and underneath the dishwasher had been thoroughly cleaned and was free of debris. 2. During an observation on 1/14/26 at 10:30 AM, the 100 Unit ice machine revealed a slimy, brownish colored substance on the inside and outside of the chute. Located on the machine was a document titled, "Ice Machine Inspection – Quarterly." The document also included the location of the inspection/log, "Long term" unit, for the year "2025." Per the log, the coils and motor were cleaned, and the filter was checked and replaced, but not dated. The log was "signed off" by the U.S. FOIA (b)(6) for each quarter. An observation of the ice machine on the "sub-acute" unit, on 01/15/25 at 8:35 AM, revealed the same brownish colored substance on the chute, along with slimy blackish-brown and white bio-growth on the metal areas of the chute assembly. The unit also included a log that revealed the coils and motor were cleaned, dated 12/13/25, and the filter was checked and replaced quarterly. During an interview on 01/15/25 at 9:10 AM, the Housekeeper (HK) 1 was asked who was responsible for the ice machines and he/she advised that maintenance was responsible for maintaining the ice machine. During an interview on 01/15/26 at 11:28 AM, the U.S. FO stated that the maintenance department was responsible for "wiping down the machine daily," the ice machine regularly, which included taking the machine apart every 90 days to clean the internal parts. Review of the U.S. Food and Drug Administration's (FDA) 2022 Food Code, dated 01/08/25 and located at https://www.fda.gov/food/fda-food-code/food-code-2022, page 114, revealed ice makers should be cleaned, " (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold." Review of the facility's policy titled, "General Kitchen Sanitation," dated June 2019, revealed "The Facility recognizes that food-borne illness has the	F0812	Continued from page 5 brownish colored substance on the inside and outside of the chute and chute assembly. Any dirt, grease or debris identified will be addressed immediately and further education as necessary. Results of the audits will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x 4 quarters.	02/17/2026

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F0812 SS = F	Continued from page 6 potential to harm patients/residents. All Dietary employees will maintain clean, sanitary kitchen facilities in accordance with the county health department regulations and the current Federal and State Food Codes in order to minimize the risk of infection and food borne illness." Step one of policy procedure revealed to "Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all tableware, kitchenware and food contact surfaces and equipment." NJAC 8:39-17.2(g)	F0812		02/17/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.	F0582	R#5 is [NJ Exec Order 26.] on Medicare Part A Skilled Services. R#32 is [NJ Exec Order 26.] on Medicare Part A Skilled Services. Facility Administrator re-educated [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] on 1/15/26 on the requirement to ensure Notice of Medicare Non-Coverage (NOMNOC) notifications are provided timely. 2. All residents on Medicare Part A Skilled Services have the potential to be affected by this deficient practice. The NOMNOC notifications for the last 2 months were reviewed to ensure they were provided timely and no discrepancies were found. Facility Administrator re-educated [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] on 1/15/26 on the requirement to ensure Notice of Medicare Non-Coverage (NOMNOC) notifications are provided timely. This education will be provided annually, to any new Social Worker and as needed. 4. Facility Administrator or designee will audit all NOMNOC notifications along with the Facility Social Worker x 4 weeks, 4 NOMNOCs a week x3 months and 2 NOMNOCs a week x 6 months to ensure timely notifications. Any NOMNOCs found to be out of compliance will be corrected immediately, and an in-service will be provided to the [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)]. Results of the audits will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and	02/17/2026

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F0582 SS = D	Continued from page 7 (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNOC) notification was provided timely for two of three residents (Resident 5 and R32) reviewed for beneficiary notification of 27 sample residents. This had the potential to affect all residents being discharged from services. Findings include: 1. Review of R5's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed [redacted] was admitted to the facility on [redacted] with diagnoses including [redacted] Review of R5's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] and located in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] Review of R5's "SNF [Skilled Nursing Facility] Beneficiary Notification Review" form revealed Medicare Part A skilled services start date was [redacted] and the last day covered was [redacted] Further review revealed Advance Beneficiary Notice of Noncoverage (ABN) notification was dated [redacted] and had initials written on the signature line. Review of R5's "Nurse's Note" located in the "Notes" tab of the (EMR) and dated [redacted]	F0582	Continued from page 7 recommendations during quarterly meetings x 4 quarters.	02/17/2026

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F0582 SS = D	Continued from page 8 and [redacted] revealed no documentation related to a discussion with R5 about notice of [redacted] noncoverage. During an interview on 01/15/25 at 3:40 PM with R5's [redacted] who stated he/she was [redacted] about R5's right to appeal his/her [redacted] benefits ending. The [redacted] stated he/she was [redacted], and he/she [redacted] for R5 to [redacted] the [redacted] form in his/her place. He/she said R5 would [redacted] what he/she was [redacted]. The [redacted] stated he/she would have liked to have been made aware about the right to appeal because he/she certainly would have thought about if he/she should have appealed had he/she been made aware. 2. Review of R32's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on [redacted] with diagnoses including [redacted] and [redacted]. Review of R32's quarterly "MDS" with an ARD of [redacted] and located in the EMR under the "MDS" tab revealed a "BIMS" score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted] Review of R32's "SNF Beneficiary Notification Review" form revealed [redacted] start date was [redacted] and the last day covered was [redacted]. Further review revealed ABN was dated [redacted] and it stated [redacted] to [redacted]. Review of R32s "Nurse's Note" located in the "Notes" tab of the (EMR) and dated [redacted] and [redacted] revealed no documentation related to a discussion with R32's [redacted] about notice of R32's [redacted] noncoverage. Further review revealed no note related to a discussion with R32 or [redacted] to [redacted] the form. During an interview on 01/15/25 at 12:15 PM, R32 was [redacted] the [redacted] and stated he/she was [redacted] due to his/her [redacted]. R32 stated he/she was not [redacted] that he/she had a right to appeal. He/she said that was [redacted] to him/her. R32 said he/she [redacted] of [redacted] to [redacted] the [redacted] form. During an interview on 01/15/26 at 1:43 PM, the [redacted] said when a resident needed to be notified of noncoverage of [redacted] he/she spoke with the family, and the residents and	F0582		02/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

(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
F0582 SS = D	Continued from page 9 made them aware their benefits would be stopped. [redacted] stated he/she gave them their last covered day, and if they remained in the facility, he/she would explain to them their rights to appeal. [redacted] said he/she did not document those conversations in the EMR anywhere. He/she stated if there was an [redacted] he/she reached out to them. He/she said a resident who had a BIMS of lower than 10 would not be appropriate to sign the forms therefore he/she spoke to the family. He/she said she spoke with R5's [redacted] who was [redacted] to [redacted] and stated the [redacted] him/her to have R5 [redacted] the form. [redacted] said when he/she spoke with R32, he/she [redacted] to [redacted] the form but did not document that conversation in the EMR. [redacted] stated he/she usually documented that on the form, but he/she did not on R32's and he/she was unsure why he/she did not. During an interview on 01/15/26 at 2:05 PM, the U.S. FOIA (b)(6) [redacted]) stated he/she was not clinical and did not want to provide his/her expectations related to something not clinical. Review of the facility's policy titled, "Advanced Beneficiary Notices," revised 09/25 revealed it is the policy of the facility to provide timely notices regarding Medicare eligibility and coverage. NJAC 8:39-5.1(a)	F0582		02/17/2026
F0656 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	F0656	R#11 Care Plan for [redacted] was developed on 01/13/2026 by Registered Nurse and interventions were updated based on Resident identified [redacted] Resident is [redacted] the [redacted] of Facility [redacted]. A [redacted] inservice was conducted by the Director of Nursing for the U.S. FOIA (b)(6), U.S. FOIA (b)(6) [redacted] U.S. FOIA (b)(6) and Licensed Nurse Unit Managers on the need to ensure that any resident with a Dx of PTSD has a Care Plan developed to ensure that the Resident receives proper psychological services to help maintain a comfortable and safe life. All residents with a Dx of PTSD have the potential to be affected by cited deficient practice. An audit was done of all current patients to ensure anyone with a PTSD Dx has a corresponding Care Plan and there is no one else with that diagnosis. An Inservice was initiated by the Director of Nursing on 01/13/2026 and 2/2/2026 and is ongoing for U.S. FOIA (b)(6), U.S. FOIA (b)(6) [redacted] U.S. FOIA (b)(6) and Licensed Nurse Unit Managers on	02/17/2026

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PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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F0656 SS = D	Continued from page 10 under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to develop a care plan for one of two residents (Resident (R) 11) reviewed for NJ Ex Order 26.4(b)(1) status of 27 sample residents. This failure could interfere with the resident receiving proper NJ Ex Order 26.4(b)(1) services to help maintain a comfortable, safe life. Findings include: Review of R11's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed he was initially admitted to the facility on NJ Exec Order 26 and readmitted on NJ Exec Order 26 with NJ Exec Orde NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1), NJ Exec Order 26 Review of R11's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26 and located in the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of NJ Ex out of 15 which indicated R11 had NJ Exec Or NJ Exec Order 26.4 . The "MDS" also indicated R11 had	F0656	Continued from page 10 the need to ensure that any resident with a Dx of PTSD has a Care Plan developed to ensure that the Resident receives proper psychological services to help maintain a comfortable and safe life. This in service will be given to any new Social Worker, Licensed Nurse MDS Coordinator and License Nurse Unit Manager during orientation, annually and as deemed necessary. An audit tool was developed on 2/2/2026 to utilize for auditing the Residents with a diagnosis of PTSD to ensure that the care plan is developed. 4. The Director of Nursing and/or the Regional Nurse will conduct an audit for five Residents with completed MDS Comprehensive Assessment weekly x 4 weeks and then monthly x 3 months to ensure that Care plans for PTSD diagnosis are developed. Any negative findings will be corrected and addressed through one on one in-service and/or progressive disciplinary measures deemed appropriate by the Director of Nursing. Results of the audits will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings and the necessity for continued audits will be decided.	02/17/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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F0656 SS = D	Continued from page 11 diagnosis of [NJ Exec Orde] Review of R11's "CAA [Care Area Assessment] Worksheet," dated [NJ Exec Order 26], revealed R11's [NJ Exec Ord] interview [NJ Exec Order 26.] an actual '[NJ Exec Order 26.4b1] related to [NJ Exec Orde] Review of R11's "Care Plan," under the "care plan" tab of the EMR, revealed there were no care plans addressing R11's diagnosis of [NJ Exec Orde]. During an interview on 11/21/25 at 1:05 PM, the [U.S. FOIA (b)(6)]) stated he/she should have created a care plan for R11's [NJ Exec Orde] diagnosis. The [U.S. FOIA] stated R11 [NJ Exec] a [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] that because the diagnosis was listed on the [NJ Exec Order 26.4b1] assessment and on [NJ Exe][NJ Exec] sheet. The [U.S. FOIA] stated they should have created a care plan. Review of the facility's policy titled, "Comprehensive Care Plans," dated 08/25, revealed "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 include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that are identified in the resident's comprehensive assessment." NJAC 8:39-11.2(e) thru (i) NJAC 8:39-27.1(a)	F0656		02/17/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents who were assessed as requiring an [NJ Exec Orde] were	F0689	R#105 was reassessed by [U.S. FOIA (b)(6)] [U.S. FOIA (b)(6)] on [NJ Exec Order 26.4b1] and deemed a [NJ Exec Order 26.4b1] not [NJ Exec Order 26] a [NJ Exec Order 26.4b1] and a [NJ Exec Order 26] evaluation was correctly documented in the electronic medical record. This information was communicated again with the Activities Director on 1/14/2026. All smokers have the potential to be affected by this cited practice. An audit was done on 1/14/2026 by the Regional Nurse for all smokers to ensure the smoking evaluations appropriately reflects the use of smoking apron and no other discrepancies found. An inservice was initiated on 2/2/2026 by the Regional Nurse and is ongoing for licensed nurses	02/17/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE , EWING, New Jersey, 08628

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F0689 SS = D	Continued from page 12 provided with an [NJ Exec Order] while [NJ Exec Order 26] for one of two residents (Resident (R) 105) reviewed for [NJ Exec Order 26] out of 27 sampled residents. This has the potential to affect all residents who [NJ Ex Order 26] Findings include: Review of R105's "Admission Record" in the "Profile" tab of the electronic medical record (EMR) revealed he was admitted to the facility on [NJ Exec Order 26.4] with diagnosis of NJ Exec Order 26.4b1 of the [NJ Exec Order] Review of R105's admission "Minimum Data Set (MDS)" under the "Minimum Data Set (MDS)" tab of the EMR revealed an assessment was [NJ Ex] in [NJ Exec Order 26.4] No Assessment Reference Date (ARD) available. Review of R105's "Care Plan" located under the "Care Plan" tab of the EMR, dated [NJ Ex Order 26.4(b)] revealed R105 was care planned for [NJ Exec Order 26.4b] to [NJ Exec Order 2]. Interventions in place were that the resident [NJ Exec Order 26] [NJ Exec Order 26.4b1] while [NJ Exec Order 26.] Review of R105's "Nursing Admission Assessment" located under "Assessments" tab in the EMR, dated [NJ Ex Order 26.4(b)] revealed R105 was [NJ Exec Order 26] for [NJ Exec Order 26] and [NJ Exec Order 26] an [NJ Exec Order] while [NJ Exec Order 26.4] During observations on 01/14/26 at 10:00 AM and 2:00 PM revealed R105 [NJ Exec Order 26] without an [NJ Exec Order] During an interview on 01/14/25 at 2:18 PM, the U.S. FOIA (b)(6)) stated all residents who wanted to [NJ Exec Order] were assessed on admission or when they informed staff they wished to [NJ Exec Order]. The [U.S. FO] stated nursing completed the assessment and would verbally inform him/her when a resident required an apron. The [U.S. FO] stated he/she had access to review the [NJ Exec Order 26] assessments, but he/she did not review R105. He/she said U.S. FOIA (b)(6) U.S. FOIA (b)(6)) [NJ Exec Order 26] him/her R105 was a [NJ Exec O] [NJ Exec Order 2] and [NJ Exec Or] [NJ Exec Order] an [NJ Exec Order] while [NJ Exec Order 26.]. The [U.S. FO] said he/she was [NJ Exec Order 26] R105's assessment indicated he/she was [NJ Exec Order 26.] or that he/she [NJ Exec Order 26] an [NJ Exec Order] During an interview on 01/14/26 at 2:40 PM, the [U.S. FOIA (b)] stated he/she did not remember telling the [U.S. FO] that R105 was assessed as a [NJ Exec Order 26.4b1]. He/she reviewed the [NJ Exec Order 26] assessment, dated [NJ Exec Order 26], and [NJ Exec Order 2] it [NJ Exec Order 26] he/she was a NJ Exec Order 26.4b1 and [NJ Exec Order] an [NJ Exec Order] He/she said based on the assessment he/she should be [NJ Exec Order 2] an [NJ Exec Ord] and not [NJ Exec Order 26] without one.	F0689	Continued from page 12 regarding the need to ensure accuracy of smoking evaluations in regard to Smoking Apron use. This in service will be given to any new nurse during orientation, annually and as deemed necessary. During clinical meeting, a new Resident who requires smoking apron or a change in the smoking status of a current Resident requiring smoking apron will be communicated to the Activities Director who will update the Smoking List accordingly. 4.The Regional Nurse or Nurse Designee will audit five Residents' Smoking Evaluation x four weeks and monthly for 3 months vs Activities Smoking list to ensure accuracy of apron use during smoking activity. Negative findings will be reported to the Facility Administrator and will be corrected and addressed through one on one re-education by the Director of Nursing. Results of the audits will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x 4 quarters and will decide the necessity for further audits.	02/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

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PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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F0689 SS = D	Continued from page 13 During an interview on 01/15/26 at 2:05 PM the U.S. FOIA (b)(6)) stated a NJ Exec Order 26 assessment was completed for all residents wishing to NJ Exec Orde. The U.S. FOIA (b stated nursing staff would communicate that information to the U.S. FOIA (b)(6) U.S. FOIA (b)(6) and that the information on the assessment should be followed if they did or did not require adaptive equipment while NJ Exec Order 26.4 He/she said the interdisciplinary (IDT) team should have reviewed R105's NJ Exec Order 26 assessment along with the U.S. FO. He/she said patient safety had to be maintained and that he/she expected whatever was on the assessment to be followed or if there was any discrepancy that should be addressed prior to a resident NJ Exec Order 26. The U.S. FOIA (b said when he/she completed R105's assessment she clicked the wrong button, but it was not reviewed, and it should have been. Review of the facility's policy titled, "Resident Smoking Policy," revised 10/25, revealed this facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Residents who smoke will be further assessed, using the Safe Smoking Evaluation to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. NJAC 8:39-5.1(a)	F0689		02/17/2026
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F0700	R#105 was re-assessed on NJ Exec Order 26.4b by Licensed Nurse Unit Manager for use of NJ Ex Order 26.4(b alternatives were NJ Exec O and NJ Exec Order 26.4b1 were NJ Exec Order 26.4b to R#105. It was determined that NJ E NJ Ex Order 26.4(for R#105 were for NJ Exec Order 2 and corresponding Physician's order, consent and care plan were accurate. A one-on-one in service was conducted for the Licensed Nurse Unit Managers by the Director of Nursing to ensure that for every Resident, before the installation/use of side rails, appropriate alternative measures are offered/attempted, consent obtained and physician order and care plan are appropriate to ensure that using side rails does not lead to potential restraint or side rail entrapment. All residents who use side rails can potentially be affected by cited practice.	02/17/2026

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F0700 SS = D	Continued from page 14 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of NJ Ex Order 26.4(b) for one of four residents (Resident (R) 105) reviewed for NJ Ex Order 26.4(out of 27 sampled residents. The lack of alternate NJ Ex Order 26 measures and proper assessment/consent could lead to potential NJ Ex Order 26.4 or NJ Ex Order 26.4(b)(1). Findings include: Review of R105's "Admission Record" in the "Profile" tab of the electronic medical record (EMR) revealed he was admitted to the facility on NJ Exec Order 26.4 with diagnosis of NJ Exec Order 26.4b1 of the NJ Exec Ord Review of R105's admission "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR revealed an assessment was NJ Exec Order 26.4b1. The Assessment Reference Date (ARD) was not available. Review of R105's "Care Plan" located under the "Care Plan" tab of the EMR, dated NJ Ex Order 26.4(b revealed R105 was NJ Exec Order 26.4b1 for [redacted] Order 26.4(b)(1) Review of R105's "Physician Orders" located under the "Orders" tab in the EMR, dated NJ Ex Order 26.4(b revealed,' [redacted] NJ Ex Order 26.4(b per resident [redacted] and to promote a sense of security and to NJ Exec Ord with NJ Exec Order 26 and NJ Exec Order 26.4b1." Review of R89's "Nursing Admission Assessment" located under "Assessments" tab in the EMR, dated NJ Ex Order 26.4(b revealed no documentation that alternates were explored prior to NJ Ex Order 26.4(b)(1). During observations on 01/12/25 and 01/13/25, there were NJ Ex Order 26.4(on NJ Ex Order 26.4(b)(of R105's bed. During an interview on 01/15/26 10:20 AM the U.S. FOIA (b)(6)) stated on admission, staff would assess for NJ Ex Order 26.4(b)(1) and their NJ Ex Order 26.4 The U.S. FOIA (b) stated he/she thought there was a process to assess alternates before, but it has been a while. He/she said they didn't complete the process of exploring alternatives, and he/she was	F0700	Continued from page 14 A facility wide side rail re- assessment was started on 2/6/2026 and is ongoing by Licensed Nurse Unit Managers, Licensed Nurse Infection Preventionist and the Director of Nursing to ensure appropriate alternatives prior to installing bed rail were exhausted, risks vs benefits of bed rails with resident or resident representative were discussed, informed consents were obtained prior to installation/use. An Inservice was started on 2/2/2026 for licensed nurses, licensed nurse supervisors, and Licensed Nurse Unit Managers and is ongoing by the Director of Nursing to ensure that for every Resident, before installing/use of side rails, appropriate alternatives are discussed and offered, consent obtained and physician order and care plan are appropriate to ensure that using side rails does not lead to potential restraint or side rail entrapment. This in-service will be given during orientation for a newly hired license nurses, annually, and as deemed necessary by the DON or the nurse educator. Facility side rail consent forms were reviewed and updated on 2/2/26 by the Director of Nursing to address risks vs benefits, and available alternative measures before the utilization of side rail. Inservice on the revised Consent form was initiated by the Director of Nursing to the license nurses and is ongoing, Director of Nursing or designee will review all new admissions to ensure alternatives to side rails were offered prior to use of side rails x1 month, then 4 admissions a week x3 months, then 2 admissions a week x 4 months. Any resident found to have side rails placed without proper alternatives offered or consent will be immediately corrected, and appropriate staff member re-educated by the Director of Nursing or the license nurse unit manager. Results of the audits will be submitted to the Quality Assessment and Assurance Committee (QAA) for review and recommendations during quarterly meetings and will decide the necessity for further audits.	02/17/2026

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F0700 SS = D	Continued from page 15 unsure if that was part of the current process. He/she stated all [NJ Ex Order 26.4(b)] in the facility were already on the bed for resident use. During an interview on 01/15/26 at 2:05 PM, the [U.S. FOIA (b)(6)]) said [NJ Ex Order 26.4(b)] were on all the beds. The [U.S. FOIA] stated there was an assessment completed and they got the consent from the resident or responsible party. He/she stated if they did not give consent; the [NJ Ex Order 26.4(b)] were removed. He/she stated [NJ Ex Order 26.4(b)] were used as enablers and were only [NJ Ex] He/she said they were not used as a [NJ Ex Order 26.4(b)] and staff did not look at alternatives since they were not used as [NJ Ex Order 26.4(b)] Review of the facility's policy titled, "Proper Use of Side Rails," revised 11/25, revealed the purpose of these guidelines is to ensure the safe use of side rails as resident mobility aides and to prohibit the use of side rails as restraints. NJAC 8:39-27.1(a)	F0700		02/17/2026

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PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/14/2026 in relation to the 1/15/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		04/14/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - CARE ONE A...** B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

(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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/14/26 and the facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Preferred Care Center at Mercer is a two-story building that was built in the 1960's. It is composed of Type V (111) protected construction. The facility is divided into 3 smoke zones. The 300 KW diesel generator powers 100% of the building per U.S. FOIA (b)(6). The number of beds occupied was 85 out of 100.	K0000		02/17/2026
K0511 SS = F Bldg. 01	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that nonmetallic-sheathed wiring splice was either in a junction box or in a permitted enclosure in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 300.15 (B). This deficient practice had the potential to affect all 36 residents who resided in this wing of the facility and was	K0511	On 1/19/26 Facility Maintenance Director rewired the exhaust fan in the utility closet to ensure all spliced wired were wired inside the permitted enclosure. A visual inspection was done for all exhaust fans in the other utility closets and all were wired correctly with no non-metallic sheathed wiring or spliced wired outside the permitted enclosure. All residents have the potential to be affected by this deficient practice. Facility Electrician Vendor came out on 2/6/26 and inspected the facility attic and no non-metallic sheathed wiring or spliced wired outside the permitted enclosure were found. On 1/19/26 the Facility U.S. FOIA (b)(6) was re-educated by the Facility Administrator on the requirement to have all non-metallic sheathed wiring	02/17/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - CARE ONE A... B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE , EWING, New Jersey, 08628

(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
K0511 SS = F Bldg. 01	Continued from page 1 evidenced by the following: An observation on 01/14/26 at 2:27 PM revealed an exhaust fan in the utility room across from room 136 was wired with non-metallic-sheathed wiring, wire spliced outside the permitted enclosure in the attic. During an interview at the time of the observation, the U.S. FOIA (b)(6) verified the wire splice was not in the permitted enclosure. NJAC 8:39-31.2(e) NFPA 70	K0511	Continued from page 1 and all spliced wires need to be in a permitted enclosure. Facility Maintenance Director will visually inspect the exhaust fans in all three utility closets monthly x 6 months. Any electrical wiring or equipment found not in compliance will be immediately addressed and the Facility Administrator will be notified. Results of the inspections will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x 4 quarters.	02/17/2026
K0741 SS = F Bldg. 01	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This STANDARD is NOT MET as evidenced by:	K0741	On 1/14/26 Facility Maintenance Director placed a metal container with self closing lid on the smoke patio. All residents can potentially be affected by this deficient practice. Upon investigation it was determined that the facility did have a metal container with a self closing lid that was designated for the smoking patio, but it had been removed. The container was located and placed back on the patio. The facility U.S. FOIA (b)(6), the U.S. FOIA (b)(6) U.S. FOIA (b)(6) and the Activity Aides were re-educated on 1/14/26 by the Facility Administrator on the requirements for the smoke patio to always have a metal container with a self closing lid and that if the metal container ever went missing they are to report it to the Facility Administrator right away. Facility Maintenance Director will do a visual check once a month for 12 months to ensure the smoke patio has a metal container with a self closing lid. If there is no metal container, or if it gets reported that the metal container was removed, the Facility Maintenance Director will either locate or go out to purchase an additional Metal Container with a self closing lid. Results of the visual inspections will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x 4 quarters.	02/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - CARE ONE A...** B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

(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
K0741 SS = F Bldg. 01	Continued from page 2 Based on observation and interview, it was determined that the facility failed to provide metal containers with self-closing lids at the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (6). This deficient practice had the potential to affect 36 residents and was evidenced by the following: An observation on 01/14/26 at 2:02 PM of the smoking area outside near room 114 on the first floor revealed the smoking area lacked the required metal container with self-closing lid to dispose of smoking refuse. Continued observation of the area and inside of the facility revealed no metal containers with self-closing lids were available. During an interview at the time of observation, the U.S. FOIA (b)(6) confirmed that no metal container with self-closing lid was available to the smoking area and that they never had a metal trash can with self-closing lid. NJAC 8:39-31.2(e)	K0741		02/17/2026
K0225 SS = E Bldg. 01	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure stairs located outside the exit door were equipped with a handrail in accordance with NFPA 101 Life Safety Code (2012 Edition) section 7.2.2.4.1.1. This deficient practice had the potential to affect all 18 residents and was evidenced by the following: An observation on 1/14/26 at 1:43 PM revealed that the stairs outside the corridor near room 141 were not provided with at least one 1 ½ inch in diameter circular, graspable handrail on the two steps below the intermediate landing. The exterior stairs are designated exit discharge. During an interview at the time of observation, the	K0225	Facility Handrail vendor was contacted on 2/3/26 and installed handrails on 2/12/26. An audit was done of all 6 exits and one more was found to be missing partial handrails. All residents can potentially be affected by this deficient practice. Facility Handrail vendor was contacted regarding installation of both required handrails installed them on 2/12/26. Facility U.S. FOIA (b)(6) was re-educated on 1/14/26 by the Facility Administrator on the requirement to have all stairs located outside an exit door to be equipped with appropriate handrails in accordance with NFPA 101 Life Safety Codes. Facility Administrator or designee along with the Facility Maintenance Director will conduct a visual tour of all exits every 6 months for 1 year to ensure all stairs located outside an exit door have proper and sturdy handrails. The facility Handrail Vendor will immediately repair any handrail that is found to	02/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - CARE ONE A...** B. WING	(X3) DATE SURVEY COMPLETED **01/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

(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
K0225 SS = E Bldg. 01	Continued from page 3 U.S. FOIA (b)(6) and U.S. FOIA (b)(6) confirmed that the exterior stairs did not have a handrail below the intermediate landing. NJAC 8:39-31.2(e)	K0225	Continued from page 3 be missing or in poor condition. Results of the audits will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x 4 quarters.	02/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/14/26. The facility was found to be in compliance with 42 CFR 483.73	E0000		02/17/2026

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315487	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - CARE ONE A...** B. WING	(X3) DATE SURVEY COMPLETED **03/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE , EWING, New Jersey, 08628**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 3/30/2026 in relation to the 1/15/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		03/31/2026

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