STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315487	A. BUILDING _____ B. WING _____	C 08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE EWING, NJ 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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaints # NJ 160220, NJ 162387, NJ 163020, NJ 167083, NJ 171699, and NJ 172959 Census: 81 Sample Size: 19 + 3 Closed Records 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. A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 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: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that Minimum Data Sets (MDS), an assessment tool, were accurate. This deficient practice was	F 641	1. Current MDS for resident #66 was reviewed and was correctly coded to reflect NJ ex order 26.4b1 . On NJ ex order 26.4b1 previous NJ ex order 26.4b1 MDS assessments for resident #66 were	9/6/24

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

Electronically Signed | 08/14/2024

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

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F 641	Continued From page 1 identified for 1 of 22 residents (Resident #66) reviewed for MDS and was evidenced by the following: This is a repeat deficiency. On 07/17/2024 at 10:38 AM, the surveyor observed Resident #66 being NJ ex order 26.4b1 . The resident's NJ ex order 26.4b1 NJ ex order 26.4b1 On 07/19/2024 at 8:49 AM, the US FOIA (B) (6) stated that Resident #66 NJ ex order 26. A review of the hybrid medical records (MR) revealed that Resident #66 NJ ex order 26.4b1 dated NJ ex order 26.4b1 , NJ ex order 26.4b1 and NJ ex order 26.4b1 A review of the Order Summary Report active orders as of NJ ex order 26.4b1 , included orders dated NJ ex order 26.4b1 , for NJ ex order 26.4b1 NJ ex order 26.4". A review of the resident-centered, on-going Care Plan (CP) included but was not limited to a focus area NJ ex order 26.4b1 A review of the Pre-Admission Screening and Resident Review (PASRR) dated NJ ex order 26.4b1 , identified	F 641	corrected and resubmitted by the Regional MDS nurse to reflect diagnosis of NJ ex order 26.4b1 . The US FOIA (B) (6) who made the identified MDS coding errors no longer works for the facility. 2. All residents that have a diagnosis of Schizoaffective Disorder have the potential to be affected by the cited deficient practice. MDS assessments for residents with a diagnosis of Schizoaffective Disorder were reviewed for the past year and no further coding errors were identified. 3. As part of orientation, the Regional MDS nurse in-serviced the new US FOIA (B) MDS accuracy with emphasis on properly identifying diagnosis of Schizoaffective Disorder. As a proactive approach, in-service education was initiated by the Director of Nursing on 7/29/24 to members of the IDC Team who have the responsibilities of completing sections of MDS assessments, regarding coding accuracy. This in-service education is ongoing, and will be given to any newly hired US FOIA (B) , clinical staff members with job description of coding MDS assessments, during orientation, annually and as deemed necessary. An audit form was created on 8/12/2024 to utilize as an audit tool for MDS coding accuracy. 4. The Regional MDS nurse and/or designee, utilizing the newly created audit	

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F 641	Continued From page 2 Resident #66 as NJ ex order 26.4b1 [redacted] A review of nine [redacted] Medication Use screening forms dated: NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1 all documented Resident #66 NJ ex order 26.4b1 [redacted]. A review of NJ ex order 26.4b1 [redacted] dated: NJ ex order 26.4b1 [redacted] all documented Resident #66 [redacted] A review of the MDS' Section I Psychiatric/Mood Disorder for Resident #66 revealed the following inaccuracies: Dated NJ ex order 26.4b1: Bipolar [redacted], Psychotic disorder NJ ex order 26.4b1 [redacted], Schizophrenia [redacted] Dated NJ ex order 26.4b1: Bipolar [redacted], Psychotic disorder (other than schizophrenia) [redacted] Schizophrenia [redacted] Dated NJ ex order 26.4b1 Bipolar [redacted] Psychotic disorder NJ ex order 26.4b1 [redacted] Schizophrenia [redacted]. Dated NJ ex order 26.4b1 Bipolar [redacted], Psychotic disorder NJ ex order 26.4b1 [redacted] Schizophrenia [redacted] Dated NJ ex order 26.4b1 Bipolar [redacted] Psychotic disorder NJ ex order 26.4b1 [redacted] Schizophrenia [redacted]. Dated NJ ex order 26.4b1: Bipolar [redacted], Psychotic disorder NJ ex order 26.4b1 [redacted] Schizophrenia [redacted] On NJ ex order 26.4b1, the surveyor requested to interview the US FOIA (B) (6), but the US FOIA (B) (6) no	F 641	form, will audit 10 MDS assessments weekly x 4 weeks, and then monthly x 6 months to assure MDS coding accuracy with emphasis on Schizoaffective diagnosis. Any findings of coding inaccuracies will be corrected immediately, through one on one re-education, and or progressive disciplinary measures as deemed appropriate. Results of the audits will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meeting x4 quarters.	

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F 641	Continued From page 3	F 641		

longer worked at the facility.

On 07/23/2024 at 10:46 AM, the surveyor interviewed the US FOIA (B) (6) in the presence of additional surveyors. The US FOIA (B stated the US FOIA (B) (6) was responsible to review hospital records, nursing notes, diagnoses, behaviors, smoking, and any updates. She stated that information would be used to "review and capture diagnoses" and that it was important to have accurate diagnoses to see what specialist may be needed, for the care plans, "optimum patient outcomes", and that the MDS' were reviewed in care conferences.

On 07/24/2024 at 9:35 AM, the US FOIA (B acknowledged the discrepancies in the MDS' and stated that they have all been corrected and resubmitted.

A review of the facility provided job description, US FOIA (B) (6) ", signed and dated by the previous US FOIA (B) (6) on NJ ex order 26.4b1, included but was not limited to; Job Description " ... overseeing the full collaborative, interdisciplinary assessment and care planning process ... collection and transmission of data ..." Principle Duties: "completes accurate coding of the MDS with information obtained via medical record reviews, observations, and interviews with the facility staff, resident and family members."

A review of the facility provided job description, "US FOIA (B) (6) signed and dated by the US FOIA (B on NJ ex order 26.4b1 included but was not limited to; "M. Supervise, by daily rounds and conferences, the work of all nursing personnel." "AF. Supervise the US FOIA (B) (6) to ensure that all MDS forms are completed

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F 641	Continued From page 4 accurately and in a timely manner." A review of the facility provided policy, "Minimum Data Set Policy and Procedure", revised 09/2023, included but was not limited to; "Policy: In compliance with federal and state regulations, each resident shall have a comprehensive assessment of his/her functional capacity recorded on a designated MDS form ..."General Information: "The MDS Coordinator will be responsible ... to keep assessment data current at all times." Suggested reference areas to support MDS completion: "... b. current plan of care ... c. MD (medical doctor) notes/orders ... g. medication record/treatment record ... h. medical consults ... k. documentation from other disciplines."	F 641		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that a resident who needed [NJ Ex Order 26.4b1] was provided such care, consistent with professional standards of practice by failing to document the use of [NJ Ex Order 26.4] in the Electronic Medical Record	F 695	1. The nurses who were involved in the cited deficient practice were provided with one on one re-education by the Director of Nursing on 7/19/2024 regarding the facility's policy of signing out the e-TAR when administering PRN oxygen.	9/6/24

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F 695	Continued From page 5 (EMR) for 1 of 2 residents (Resident #46) reviewed for NJ Ex Order 26.4b1 This deficient practice was evidenced by: On 07/17/2024 at 10:30 AM during the initial tour, the surveyor observed Resident # 46 in bed. Resident # 46 was observed NJ ex order 26.4b1 On 07/18/2024 at 10:11 AM, the surveyor observed Resident # 46 in bed. Resident # 46 NJ ex order 26.4b1 A review of Resident # 46's Admission Record located in the EMR revealed that Resident # 46 was admitted to the facility with diagnoses that included but NJ ex order 26.4b1 A Review of Resident # 46's physicians orders located in the EMR revealed that he/she had an NJ ex order 26.4b1 The order was started on NJ ex order 26.4b1. A review of the NJ Ex Order 26.4b1 Treatment Administration Record (TAR) NJ ex order 26.4b1 for Resident # 46. On 07/23/2024 at 11:12 AM, during an interview with the surveyor, Licensed Practical Nurse (LPN) #1 said "We give PRN [when required] orders upon request. We check the orders, inform the	F 695	2. All residents with a physician order of PRN oxygen use have the potential to be affected by the cited deficient practice. Review of three (3) other resident charts with a physician PRN oxygen order were reviewed, all were found to be signed out in the e-TAR. 3. A facility wide re-education to license nurses was initiated by the Director of Nursing on 7/19/2024 regarding facility's policy to document in the TAR every time PRN Oxygen is being administered in accordance with the facility's policy on Oxygen administration. This in-service is ongoing and will be given to any newly hired license nurse during orientation, annually and as deemed necessary. 4. The Director of Nursing or nurse designee will conduct random audits for 5 residents with a physician order of PRN oxygen administration to assure that proper documentation is completed in the TAR□s. The audits will be done weekly x4 weeks and then monthly x 6 months. Any negative findings will be corrected immediately by one-on-one education and/or progressive disciplinary measures as deemed appropriate. 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 x3 quarters.	

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F 695	Continued From page 6	F 695		

Doctor, sign the order out, and then check the resident in an hour to see if medication was effective." At that time, the surveyor asked to show where it was documented that Resident #46 NJ ex order 26.4b1 and NJ ex order 26.4b1 LPN #1 replied, "I don't see it documented anywhere." Lastly, the surveyor asked if the order for NJ ex order 26.4b should be signed out on the TAR. LPN #1 replied, "Yes."

On 07/24/2024 at 09:42 AM during an interview with the surveyor, the US FOIA (B) (6) said they [nursing staff] should be signing out the NJ ex order 26.4b1 on the TAR.

A review of the facility-provided policy titled, "PRN Medications" revised on 1/2024 revealed under section "Policy Explanation and Compliance Guidelines" that, "3. When administering a PRN medication: a. Verify physician's order for the medication. b. Document the reason voiced by the resident and or assessment findings that show why the resident needs the medication. Verify the reason is for the prescribed indication for the medication. c. Document the time of administration. d. Evaluate the effectiveness of the medication and document the findings."

A review of the facility-provided policy titled, "Oxygen Administration" revealed under "Procedures" that, "9. Document initiation of oxygen in the resident medical record, including time, flow, indication and method: cannula or mask, in the TAR (Treatment Administration Record and or progress notes). Document use and resident reaction to oxygen."

N.J.A.C. 8:39-29.2 (d)

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New Jersey Department of Health

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	476003	A. BUILDING: _____ B. WING _____	C 08/06/2024

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		

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

Electronically Signed | 08/14/24

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
315487 Y1	A. Building B. Wing Y2	9/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE EWING, NJ 08628

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 F0695	Correction	ID Prefix	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.25(i)	Completed	Reg. #	Completed
LSC	09/06/2024	LSC	09/09/2024	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	
8/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/05/2024 and 08/06/2024. Preferred Care at Mercer was found to be in noncompliance with the requirement for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Preferred Care at Mercer is a single-story building that was built in November 2004. It is composed of Type V protected construction. The facility is divided into 3 smoke zones.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	K 222		9/6/24

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

Electronically Signed | 08/14/2024

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K 222	Continued From page 1 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	K 222		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE** **EWING, NJ 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
K 222	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/06/2024, in the presence of the US FOIA (B) (6) [redacted]) and US FOIA (B) (6) [redacted] it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101:2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 8:50 AM in the presence of the US FOIA (b)(6), revealed one set of glass sliding doors located at the front entrance of the facility had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. An observation at 9:21 AM in the presence of the US FOIA (b)(6), revealed an exit accesses door next to administrator office with exit sign indicating an exit. The exit door had keyed lock device installed. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (B) (6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/06/2024. N.J.A.C. 8:39-31.2(e)	K 222	1. The lock on the glass sliding doors was disabled on 8/6/2024. The keyed lock device on the exit door by the Administrators office was removed on 8/5/2024 and replaced with a regular doorknob. 2. All residents have the potential to be affected by this deficient practice. A visual inspection was carried out on all other exit doors to ensure they were readily accessible and free of all obstructions or impediments to full instant use and all were in compliance. 3. The facility Administrator re-inserviced the US FOIA (B) (6) on the requirements to ensure all exit doors are readily accessible and free of all obstructions or impediments to full instant use in case of fire. An audit form was created to check all exit doors to ensure there are no locks and are readily accessible. Any door found to have a lock will be immediately corrected and Administrator notified. 4. The newly created Exit door audit will be done monthly x 6 months. Any door found to have a lock will be immediately corrected and Administrator notified. The facility Administrator will inspect any new exit door that is installed to ensure there are no locks and that they are readily accessible and free of all obstructions for full instant use in case of fire. Any negative findings will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315487	A. BUILDING **01** B. WING _____	**08/06/2024**

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PREFERRED CARE AT MERCER	**1201 PARKWAY AVENUE** **EWING, NJ 08628**

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K 222	Continued From page 3	K 222	corrected immediately. Results of the inspection and audit forms will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x 3 quarters.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/05/2024, in the presence of the US FOIA (b)(6) [redacted] was determined that the facility failed to ensure that space open to the corridor had smoke detection systems in accordance with NFPA 101 Life Safety Code :2012 Edition, Section 19.3.4.5.2, 19.3.6.1.(7)(a). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:17 AM in the presence of the US FOIA (b)(6), revealed the dining area had two open ways to the corridor and had no smoke detection system. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (B) (6) was notified of the deficient practice at Life Safety Code survey exit	K 347	1. The facility has a smoke detector, fire alarm and fire extinguisher outside the main dining area that are fully functional. The facility Fire Prevention vendor came out on 8/13/2024 to provide a quote to install a new smoke detector and a proposal was sent and signed on 8/16/2024. 2. All residents have the potential to be affected by this deficient practice. A visual inspection was carried out in all common areas open to corridors to ensure a smoke detector was present and no other areas were missing. The facility Fire Prevention vendor conducts a smoke detector inspection twice a year and results are kept in the Life Safety Binder. Any recommendations are acted upon immediately.	9/6/24

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	315487	A. BUILDING **01** B. WING _____	**08/06/2024**

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K 347	Continued From page 4 conference on 08/06/2024. N.J.A.C. 8:39-31.2(e) NFPA 70,72	K 347	3. The facility Administrator inserviced the US FOIA (B) (6) on the requirement to have a smoke detector in all spaces open to a corridor. 4. In addition to the facility Fire Prevention vendors bi-annual inspection, the facility Maintenance Director will visually inspect all spaces open to corridors to ensure that smoke detectors are present and functioning bi-annually. Any areas that are missing a smoke detector or are disabled will be addressed immediately. Results of the inspection will be submitted to the Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee for review and recommendations during quarterly meetings x4 quarters.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		9/6/24

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K 353	Continued From page 5 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/05/2024 and 08/06/2024, in the presence of the US FOIA (b)(6)), it was determined that the facility failed to maintain the automatic fire sprinkler system and ensuring the ceiling level was smoke resisting in accordance with NFPA 101:2012 Edition, Section 9.7.5,9.7.7, 9.7.8 and NFPA 25: 2011 Edition, Section 5.2.1.1.1(2). This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:45 AM in the closet next to room #104, revealed an opening in the ceiling. In an interview at the time, the US FOIA (b)(6) confirmed the observation. Observations on 08/06/2024 in the presence of US FOIA (b)(6), revealed the following: 1. At 11:20 AM in the laundry room, 3 of 6 sprinkler heads had corrosion buildup. 2. At 11:35 AM in the utility closet, there was a penetration in the ceiling. 3. At 11:45 AM in the kitchen, 4 of 6 sprinkler heads had corrosion buildup. 4. At 10:19 AM under the secondary entrance overhang, 2 of 2 sprinkler heads had a gap around the pipes in the ceiling.	K 353	1. Facility replaced the ceiling tile in the linen closet near room #104 on 8/5/2024. Facility closed the penetration in the utility closet on 8/5/2024. Facility closed the gaps around the sprinkler pipes in the secondary entrance overhang on 8/5/2024. The Facility Administrator reached out to the facility Fire Prevention vendor who stated that the 7 sprinkler heads cited still work properly and does not affect functioning until they can be replaced. The facility Fire Prevention vendor is scheduled to come out on 8/15/2024 to replace the cited sprinkler heads. 2. All residents have the potential to be affected by this deficient practice. A visual inspection was done on all the sprinkler heads in the kitchen and laundry areas and no further corroded sprinkler heads were identified. 3. The facility Administrator re-inserviced the US FOIA (B) (6) on the requirements to maintain the automatic fire sprinkler system and to ensure the ceiling level was smoke resistant. An audit form was created to inspect 5 sprinkler heads per month and 5 areas for penetrations per month. Any penetrations will be repaired immediately and any corroded sprinkler head will be called in to our Fire Prevention vendor and	

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K 353	Continued From page 6 In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/06/2024. N.J.A.C. 8:39-31.2(e) NFPA 13. 25	K 353	Administrator notified. 4. The Facility Administrator will review the newly created audit form monthly x 6 months. Any corroded sprinkler heads or ceiling penetrations will be addressed immediately. The Facility Administrator will report to the quarterly Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee x3 quarters.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		9/6/24

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K 363	Continued From page 7 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 08/05/2024, in the presence of the US FOIA (b)(6) [redacted] was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101:2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5. This deficient practice had the potential to affect all residents was evidenced by the following: Observations from 9:15 AM to 2:45 PM in the presence of US FOIA (b)(6) revealed the following: 1. At 9:48 AM, resident room door #106 was rubbing on the frame not latching when it was tested by US FOIA [redacted] 2. At 9:55 AM, resident room door #108 was not latching to its frame when it was tested by US FOIA [redacted] 3. At 10:23 AM, resident room door #139 had an open gap on top when it was tested by US FOIA [redacted].	K 363	1. Room 106 door was corrected on 8/5/2024. Room 108 door was corrected on 8/5/2024. Room 139 door was corrected on 8/5/2024. Emergency Electrical room door knob was replaced on 8/6/2024. 2. All residents have the potential to be affected by this deficient practice. A visual inspection was done on 8/5/2026 for all other resident rooms and all doors were found to close and latch properly. A visual inspection was done on 8/5/2026 on all other electrical room doors and all were found to close and latch properly. 3. The Facility Administrator re-inserviced the US FOIA (b)(6) [redacted] on the requirement to ensure all corridor doors are able to resist the passage of smoke. A new audit form was created to have 5	

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K 363	Continued From page 8 4. At 11:32 AM, the Emergency Electrical room door was not latching to its frame when it was tested by US FOIA In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/06/2024. N.J.A.C. 8:39-31.2(e).	K 363	doors checked every week for 6 months. Any door that does not close or latch properly will be addressed immediately and the Administrator notified. 4. The Facility Administrator will review the newly created audit form monthly x 6 months. Any door that does not close or latch properly will be addressed immediately. The Facility Administrator will report to the quarterly Continuous Quality Assurance and Performance Improvement (C-QAPI) Committee x3 quarters.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 08/05/2024 and 08/06/2024 in the presence of the US FOIA (b)(6) [redacted], it was	K 761	1. All fire door assemblies were inspected by the facility Administrator and facility Maintenance Director on 8/8/2024 and documented on the facility □Annual	9/6/24

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K 761	Continued From page 9 determined that the facility failed to ensure that the fire doors assemblies were inspected, tested and documented annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101,2012 Edition, Section 19.7.6,8.3.3.1.NFPA 80, 2010 Edition, Section 5.2,5.2.3.This deficient practice had the potential to affect all residents and was evidenced by the following: Observation and interview during the tour on 08/05/2024 from 9:15AM to 3:35PM revealed fire rated doors at various locations including, elevator machine room, horizontal exit, hazardous enclosures and exits. Documentation review on 08/06/2024 at 10:25AM revealed that the facility did not provide policy and procedures for fire door assemblies and no documentation to indicate fire door assemblies were inspected and tested. In an interview at the time, the US FOIA (b)(6) confirmed the observation. The facility's US FOIA (b)(6) was notified of the deficient practice at Life Safety Code survey exit conference on 08/06/2024. N.J.A.C 8:39-31.1(c),31.2(e) NFPA 80.	K 761	Inspection of Swinging Door Assemblies form. All doors were found to be in compliance and in good working condition. 2. All residents have the potential to be affected by this deficient practice. 3. The facility Administrator inserviced the US FOIA (b)(6) on the requirement to ensure that all fire doors assemblies are inspected, tested and documented annually. The facility Maintenance Director was given a blank copy of the facility fire door assembly inspection form. 4. The facility Administrator will review the inspection form on the next annual inspection and report to the quarterly Continuous Quality Assurance and Performance Improvement (C-QAPI) at the next meeting and after the next annual inspection.	

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
315487 Y1	A. Building 01 - CARE ONE AT EWING B. Wing Y2	9/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT MERCER	1201 PARKWAY AVENUE EWING, NJ 08628

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	09/09/2024	LSC K0347	09/09/2024	LSC K0353	09/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0363	09/09/2024	LSC K0761	09/09/2024	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	
8/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO