

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

PRINTED: 01/26/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/28/2021
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT MERCERVILLE LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT # NJ 147076 CENSUS: 75 SAMPLE SIZE: 3 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.	F 000			
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 147076 Based on interviews, medical record reviews,	F 686			11/3/21
			Complaint Survey Date: September 28, 2021 The plan of correction is prepared and/or		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/29/2021

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 686	<p>Continued From page 1</p> <p>and review of other pertinent facility documents on 9/24/2021 and 9/28/2021, it was determined that the facility failed to provide treatment to existing [REDACTED] identified on readmission and failed to follow the facility policy for 1 on 3 residents (Resident #3) reviewed for [REDACTED] care. This deficient practice was further evidenced by the following:</p> <p>1. According to the Face Sheet Resident #3 was originally admitted to the facility on [REDACTED], and re-admitted on [REDACTED], with diagnoses which included but were not limited to [REDACTED].</p> <p>[REDACTED]</p> <p>The Minimum Data Set (MDS), an assessment tool dated [REDACTED] documented a Brief Interview for Mental Status (BIMS) score of [REDACTED] which indicated the Resident had [REDACTED]. According to the MDS, Resident #3 required [REDACTED] with [REDACTED].</p> <p>A review of the Admission/Readmission Skin Assessment dated [REDACTED], the nurse documented the following skin issues: [REDACTED]</p> <p>[REDACTED]</p> <p>Resident #3's Care Plan dated [REDACTED], revealed a [REDACTED] interventions including but not limited to: Perform treatments as ordered.</p> <p>The Physician's Order Sheet (POS) failed to show an order in place for treatment to the</p>	F 686	<p>executed solely because it is required by the provisions of Federal and State law. This plan of correction constitutes a written allegation of substantial compliance with Federal and State Medicare and Medicaid.</p> <p>F686: Treatment /Svc's to Prevent/ Heal Pressure Ulcer</p> <p>1. Resident # 3 is no longer reside at the facility.</p> <p>2. All residents have the potential to be affected by deficient practice. All residents with treatment orders for wounds were reviewed and there is no deficient practice was identified.</p> <p>3. DON/designee provided re-education from 10/28/21- 11/1/21 to all licensed nurses regarding obtaining physician orders for wound treatment and signing treatment orders upon completion of the treatment .</p> <p>4. The Director of Nursing or designee will audit all new admissions/readmissions orders to verify physician orders and will audit treatment administration record for completion of documentation beginning 11/2/21 weekly x 4, monthly x 3 to ensure compliance. . Results will be provided to the QAPI Committee monthly and ongoing for review/recommendations.</p> <p>Compliance Date: 11/3/21</p>		

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F 686	<p>Continued From page 2</p> <p>aforementioned [REDACTED] upon return from the [REDACTED] on [REDACTED].</p> <p>The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for the month of [REDACTED], failed to show a physician's order for [REDACTED] care to the [REDACTED].</p> <p>NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.</p> <p>Review of the Progress Notes from [REDACTED] failed to show any documentation by the nursing staff that treatments were being done to Resident #3's aforementioned [REDACTED].</p> <p>Continued review of Resident #3's medical record for the month of [REDACTED] showed the following:</p> <p>The POS verified the following order dated [REDACTED].</p> <p>NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.</p> <p>[REDACTED] once daily in the [REDACTED].</p> <p>The TAR confirmed the aforementioned order, however, there was no documentation to indicate that the treatment to the [REDACTED] was initiated on [REDACTED].</p> <p>The POS verified the following order dated [REDACTED].</p> <p>NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.</p> <p>[REDACTED]</p> <p>The TAR confirmed the aforementioned order,</p>	F 686			

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F 686	<p>Continued From page 3</p> <p>however, there was no documentation to indicate that the treatment to the [REDACTED] was completed on [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.</p> <p>The POS verified the following order dated [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED]</p> <p>The TAR confirmed the aforementioned order, however, there was no documentation to indicate that the [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED]</p> <p>The POS verified the following dated [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED]</p> <p>The TAR confirmed the aforementioned order, however, there was no documentation to indicate that the treatment was initiated to the [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED]</p> <p>During the interview on 9/24/21 and 9/28/2021 at 1:40 p.m., the Unit Manager (UM) stated that the staff should document by signing the MAR or TAR right after the medication/treatment to indicate it was administered. The UM stated that if [REDACTED] are not taken care of, the [REDACTED] can [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED] could result.</p> <p>During the interview on 9/24/21 and 9/28/2021 at 1:18 p.m., the Director of Nursing (DON) stated that if the MAR or TAR are not signed then you</p>	F 686			

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F 686	<p>Continued From page 4</p> <p>do not know whether the treatment was completed. The DON explained that the staff documented the [REDACTED] on [REDACTED] to the facility on [REDACTED], and the protocol is to start NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED] Consultant. However, there was no treatment in place from [REDACTED] and "we don't know what happened..."</p> <p>A review of the facility document titled "Treatment Protocol," dated [REDACTED] showed under [REDACTED] "the [REDACTED] should be [REDACTED] NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [REDACTED]..."</p> <p>A review of the facility's policy titled "Wound Care," under "Purpose:" The purpose of this procedure is to provide guidelines for the care of wounds to promote healing..."</p> <p>A review of the facility policy titled, "Wound Care," updated on 5/2021, under "Documentation" The following information should be recorded in the resident's medical record. #4: "The name and title of the individual performing the wound care."</p> <p>N.J.A.C. 8:39-27.1(e)</p>	F 686			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315094	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/8/2021
NAME OF FACILITY COMPLETE CARE AT MERCERVILLE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619	

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 F0686	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/03/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
9/28/2021

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