STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, 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 #: NJ00176679 Survey Dates: 02/27/2025, 03/11/2025 Census: 98 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 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential	F 842		4/16/25

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

Electronically Signed | 04/18/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, NJ 08619**

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F 842	Continued From page 1 all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;	F 842		

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	315094	A. BUILDING _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, 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 842	Continued From page 2 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, review of the medical records, and other pertinent facility documents on 2/27/25 and 3/11/25, it was determined that the facility failed to maintain an accurate and complete medical record in accordance with acceptable standards and practice by not updating a resident's Comprehensive Care Plan (CPP) to include a [redacted] and [redacted] intervention for 1 of 3 residents (Resident #2). This deficient practice was identified for 1 of 3 residents (Resident #2) who was reviewed for [redacted] and was evidenced by the following: According to the admission record, Resident #2 was admitted to the facility with diagnoses which included but not limited to: NJ Exec Order 26.4b1 [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the Resident's [redacted] was NJ Exec Order 26.4b1. A review of the US FOIA (b)(6) note dated [redacted] revealed that Resident #2 refused to complete his/her BIMS.	F 842	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident # 2 NJ Ex Order 26.4(b)(1) at the facility. Unit managers were immediately educated to update residents care plans after each incident. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTIC: All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON educated all Unit Managers and supervisors on the importance of updating the care plan to reflect the current interventions discussed with IDC team. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315094	A. BUILDING _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, NJ 08619**

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F 842	Continued From page 3 A review of the Progress Notes (PN) dated [redacted] at 11:47 AM revealed that Resident #2 was [redacted] on the [redacted] on the [redacted] of the [redacted] Resident #2 [redacted] any [redacted] Vital signs were checked, and [redacted] were started. A review of the PN's dated [redacted] at 09:31 revealed a late entry note by RN #2 that Resident #2's care plan was updated. A review of Resident #2's Care Plan, dated [redacted], revealed that the Resident #2 is [redacted] for [redacted] related to [redacted] A review of Resident #2's Care Plan, dated [redacted], revealed there was no documented evidence that the Care Plan was updated to reflect the [redacted] that occurred on [redacted]. There was also no documented evidence of interventions to address the [redacted] that occurred on [redacted] 12 10:52 A.M., the [redacted] stated that when a resident is admitted to the facility, she has 14 days to complete a RAP (Resident Assessment Protocol) summary, and the RAP will initiate the triggered problems that she will then review and assure they are being addressed. She stated the [redacted]) is responsible for the initial care plan. The [redacted] is also responsible for updating the care plan. The [redacted] stated that the [redacted] should have updated Resident #2's care plan to reflect Resident #2's [redacted] on [redacted]. During an interview with the surveyor on 3/11/2025 at 10:59 A.M., LPN #1/UM stated that the [redacted] oversees updating a resident's care plan if there is a change with the resident, including	F 842	PROGRAM WILL BE PUT INTO PLACE: The DON/Designee will audit 5 residents care plans post incident weekly x 4, monthly x 2. The results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly. 5. Completition date 04/16/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	**2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, NJ 08619**

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F 842	Continued From page 4 when a resident falls. LPN #1/UM stated that she should have updated Resident #2's care plan when Resident #2 [NJ Exec] on [NJ Exec Order 26.4b] During an interview with the surveyor on 3/11/2025 at 11:59 A.M., the [US FOIA (b)(6)] acknowledged that Resident #2's care plan should have been updated by the [US FOIA] to reflect resident's [NJ Exec] on [NJ Exec Order 26.4b1] NJAC 8:39-11.2(2)(h)(i)	F 842		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061106	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, NJ 08619

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S 000	Initial Comments Complaint #: NJ00176679 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00176679 Based on interviews and review of facility documents on 2/27/2025 and 3/11/2025, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	S 560	1. Inadequate number of Certified Nursing Assistants due to call offs and staff not showing off to work. 2.All the residents may be affected by the short staff as required by NJ DOH. 3.The Administrator will in-service the Staffing Coordinator in reference to the state guideline S 560. " Director of Human Resources will continue to post the vacancies in all 3	4/16/25

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

Electronically Signed | 04/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061106	A. BUILDING: _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, NJ 08619

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 02/09/2025 to 02/22/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: On 02/09/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 02/10/25 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 02/11/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 02/12/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 02/13/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 02/14/25 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. On 02/16/25 had 11 CNAs for 108 residents on the day shift, required at least 13 CNAs.	S 560	shifts. " Director of Human Resources will schedule the Open House. " The Staffing Coordinator and/or designee will post and/or offer an OT pay to in-house staff. " The Administrator, DON, and/or designee will offer a bonus on top of the overtime and/or regular hourly pay. " The Administrator will boost the rate of agency staff during a call out coverage and on weekends. " The staffing agency will block a schedule for the open position to cover for the vacancies. 4. The Staffing Coordinator and/or designee will audit the staffing weekly for 4 weeks then monthly for 3 months. The Staffing Coordinator and DON will submit the audit report to the Quality Assurance Improvement Committee. 5. Completion date 4/16/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 On 02/17/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 02/18/25 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. On 02/19/25 had 12 CNAs for 107 residents on the day shift, required at least 13 CNAs. On 02/20/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. On 02/21/25 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs. On 02/22/25 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315094 Y1	A. Building B. Wing Y2	4/23/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, 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 F0842 Reg. # 483.20(f)(5), 483.70(h)(1)-(5) LSC	Correction Completed 04/16/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/11/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061106	A. Building B. Wing	4/23/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MERCERVILLE LLC	2240 WHITEHORSE-MERCERVILLE ROAD HAMILTON TOWNSHIP, NJ 08619

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 04/16/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 3/11/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			