

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MERRY HEART NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 RT 10 WEST SUCCASUNNA, NJ 07876
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S1420	8:39-19.5(b)(3) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 3. Any employee with positive results shall be referred to the employee's personal physician or advanced practice nurse and if active tuberculosis is suspected or diagnosed shall be	S1420		11/15/21

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

TITLE

(X6) DATE

Electronically Signed

11/29/21

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MERRY HEART NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 RT 10 WEST SUCCASUNNA, NJ 07876
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1420	<p>Continued From page 1</p> <p>excluded from work until the physician or advanced practice nurse provides written approval to return.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of employee files it was determined that the facility failed to ensure that 2 of 3 new employees hired had their physical examinations conducted within the required time frame.</p> <p>The deficient practice was evidenced by the following: On 11/9/21 at 11:00 AM the surveyor reviewed three files for three newly hired employees.</p> <p>Employee number 2 received a physical examination 2 weeks and 5 days prior to hire. The employee's hire date was 7/19/21 and the physical was done on 6/30/21. Employee number 3 received a physical examination approximately 9 months prior to hire. The physical was done by a different facility's physician. The employee's hire date was 10/18/21 and the physical was done on 1/21/21.</p> <p>On 11/9/21 at 12:00 PM the surveyor spoke with the Human Resources (HR) representative and the Director of Nursing (DON) about the concern with the physical examinations being outside of the required timeframe. The DON and the HR representative acknowledged the deficient practice.</p>	S1420	<p>1. How many corrective action will be accomplished for those employees found to have been affected by the deficient practice?</p> <p>Each HR staff will be educated on the importance of complying with the 14 days physical exam completion date before a start date is determined.</p> <p>2. How will the facility identify other employees having the potential to be affected by the same deficient practice?</p> <p>All employees and residents will have the potential to be affected by the deficient practice.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>All new hires will have their physical examination within 14 days of target start date.</p> <p>If a physical examination is not done within the 14 days of target start date, the employee will not be allowed to start orientation.</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061410	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/12/2021
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MERRY HEART NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 200 RT 10 WEST SUCCASUNNA, NJ 07876
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S1420	Continued From page 2	S1420	<p>4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program will be put into place to monitor the continued effectiveness of the systematic change?</p> <p>Each new employee's medical folder will be checked by the HR Director and DON prior to the target start date.</p> <p>HR Director/Designee will report to the QAPI Committee meeting monthly until goal of 100% is achieved and committee determines that the problem is resolved</p>	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315057	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/2/2022	Y3
NAME OF FACILITY MERRY HEART NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 200 RT 10 WEST SUCCASUNNA, NJ 07876		

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 F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/24/2021	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 11/12/2021

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