STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s NJ 176377, 178498 STANDARD SURVEY: 1/10/25-1/16/25 CENSUS: 94 SAMPLE SIZE: 19+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		2/5/25

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

Electronically Signed | 02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the dignity of two unsampled residents. This deficient practice was found with 2 of 5 staff US FOIA (b)(6) and US FOIA (b)(6) observed during dining observations on the 1st- floor. The deficient practice was evidenced by the following: On 1/10/25 at 12:10 PM, during a lunch meal dining observation in the 1st-floor dining room, the surveyor observed the lunch trays being distributed to the residents by five staff members. At 12:15 PM, the surveyor observed the US FO standing while feeding an unsampled resident.	F 550	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. The US FOIA (b)(6) observed was not allowed to return to Merry Heart. The US FOIA (b)(6) identified was re-educated on the importance and value of being seated while providing help with feeding residents. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents who need assistance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 550	Continued From page 2 On 1/10/25 at 12:20 PM, the surveyor observed the [US FOIA (b)(6)] standing while feeding an unsampled resident. On 1/14/25 at 12:10 PM, during a lunch meal dining observation in the 1st-floor dining room, the surveyor observed the [US FOIA (b)(6)] standing while feeding an unsampled resident. On 1/14/25 at 12:35 PM, the surveyor interviewed the [US FOIA (b)(6)] who acknowledged that she should sit while feeding the residents as it was a dignity concern. On 1/14/25 at 12:39 PM, the [US FOIA (b)(6)] was unavailable to be interviewed. On 1/14/25 at 12:49 PM, the above concerns were discussed with the US FOIA (b)(6) [redacted]. The [US FOIA (b)(6)] confirmed that the staff should be seated when feeding the residents. No further information was provided. NJAC 8:39-4.1(a)12	F 550	feeding have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Director of nursing or designee will randomly observe lunch or dinner meals, 3x a week x 3 months in different dining rooms to ensure that staff are seated when feeding the residents. In service was provided by the Director of Nursing on Jan 28 □ 29, 2025 to the nursing staff to be seated when feeding a resident. 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 systemic change? Director of nursing /Charge nurses / designee will be assigned to check 3x/week X 3 weeks , different dining room locations & different mealtimes to ensure compliance of staff being seated when feeding residents during meals. Any identified non-compliance with be reported to Director of nursing /designee. Nursing staff who are non-compliant with new policy and procedure will receive one-on-one counselling and reeducation that can escalate to termination. Results of the audits will be submitted or reported to the monthly QAPI meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 550	Continued From page 3	F 550	until the goal of 100% compliance is achieved and the committee determines the problem is resolved. Results will be used for training and for system changes thru the QAPI committee.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583		2/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 583	Continued From page 4 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to deliver unopened mail in a timely manner for 2 of 5 residents (Resident # 5 and #2) reviewed. This deficient practice was evidenced by the following: On 1/13/25 at 10:57 AM, during the resident council meeting, Residents #5 and #2 stated that they often received their mail opened and then scotch-taped closed. The residents could not recall who had delivered the opened letters that had been addressed to them. The residents were upset and said no one should have opened their mail. Resident #5 stated that NJ Ex Order 26.4b1 [redacted] the last 2 opened envelopes yesterday, who was also very upset that someone had opened the resident's mail without permission. The surveyor reviewed the medical record for Resident #5. A review of Resident #5's Admission Record indicated that the Resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4b [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4b2 [redacted], revealed that Resident #5 had a Brief Interview for Mental Status (BIMS) score of NJ Ex [redacted] which indicated that the Resident's cognition was NJ Ex Ord [redacted]	F 583	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident # 5 & Resident # 2 both agreed ,will be checked by the Asst. Administrator/designee weekly on the status of their mails received. Root cause: US FOIA ([redacted] opened the mail addressed to the resident. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents will be have the potential to be affected by the deficient practice. 3.What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Email was sent to the families to include the name of the department on the envelope where the mail is addressed. Educated the US FOIA ([redacted] and all Department Heads on the rights of the residents to receive unopened mail. The outcome of the audit will be discussed in the monthly resident council meeting. 4. How the facility will monitor it's corrective actions to ensure that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 583	Continued From page 5 NJ Ex Order . The surveyor reviewed the medical record for Resident #2. A review of Resident #2's Admission Record indicated that the Resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4b1 [redacted] A review of the quarterly MDS dated NJ Ex Order 26.4b1 revealed that Resident #2 had a BIMS score of NJ Ex, which indicated the Resident's cognition was NJ Ex Order 26.4b1. On 1/14/25 at 9:34 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that the mail was received and sorted by the US FOIA (b) (6) and the activities staff delivered it to the residents. The US FOIA (further stated that her activity staff is not allowed to open the mail without the resident's permission. On 1/14/25 at 9:53 AM, the surveyor interviewed the US FOIA (b)(6), who explained that all business mail went to the business office and personal mail was given to the US FOIA (b for distribution. On 1/14/25 at 10:32 AM, the surveyor interviewed the US FOIA (b)(6)) and confirmed that she "sometimes mistakenly" opened Residents' mail. The US FOIA (further stated that when she opened the mail by mistake, she would tape it closed and give it back to the US FOIA (b) (6) for distribution. She never personally apologized to the residents for opening their mail. On 1/14/25 at 11:15 AM, the surveyor interviewed Resident #5's NJ Ex Order 26.4b1, who is also their NJ Exec Ord	F 583	deficient practice is being corrected and will not recur. Director of Activities/ designee will check with residents to ensure residents are receiving unopened mails. Results of weekly audits will be reported to the monthly QAPI meeting until the goal of 100% compliance is achieved and the committee determines the deficient practice is resolved. results will be used for training and for system changes thru the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 583	Continued From page 6 via telephone. The [NJ Ex Order 26.4b1] confirmed that the resident's mail had been opened and stated that the letter was delivered to the resident more than a month after the postmarked date. The facility did not deliver the opened mail to Resident #5 for four weeks after it had been received. On 1/14/25 at 11:21 AM, the surveyor interviewed the [US FOIA (b)] who acknowledged that she had accidentally opened Resident #5's two pieces of personal mail. She confirmed that she had kept the mail for more than 4 weeks without delivering it to the resident because she was "very busy". She also confirmed that she had not apologized to the resident for opening her mail but "should have." On 1/15/25 at 1:30 PM, the survey team discussed the above observations and concerns with the Administration, who confirmed that the [US FOIA (] should not open residents' mail. N.J.A.C. 8:39-4.1 (19)	F 583		
F 689 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: Complaint # NJ 00178498	F 689	1. How the corrective action will be accomplished for those residents found to	2/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 689	Continued From page 7 Based on observation, interviews, review of medical records, and facility documents, it was determined that the facility failed to follow NJ Ex [redacted] interventions as written on the resident's individual comprehensive care plan (ICCP). This deficient practice was identified for 1 of 3 residents (Resident # 14) reviewed for NJ Ex Order 26.4b1 and was evidenced by the following: On 1/10/25 at 11:09 AM, during the initial tour of the NJ Ex [redacted] floor unit, the surveyor observed Resident #14 in a reclining chair in the day room with other residents and staff members. The surveyor reviewed the medical record for Resident # 14. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4b1 A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26.4b1, revealed Resident #14 had a Brief Interview for Mental Status NJ Ex Order 26.4 of 15, indicating the resident was NJ Ex Order 26.4b1. Further review of the MDS revealed the resident was NJ Ex Order 26.4b1 staff for Activities of Daily Living (ADL) care and NJ Ex Order 26.4b1. A review of Resident # 14's Individual Comprehensive Care Plan (ICCP) revealed a Focus: NJ Ex Order 26 ... The resident is at risk NJ Ex Order 26. due to NJ Ex Order 26.4b1 .... On NJ Ex Order 26.4 had NJ Ex Order 26.4b1 ...interventions included Ensuring NJ Ex Order 26.4b1	F 689	have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. The US FOIA (b)(6) who did not follow the protocol on NJ Ex Order 26.4b1 for resident #14 was terminated. Root cause: Failure of the US FOIA (b)(. to follow NJ Exec Order 26.4b1 Policy & Procedure of NJ Exec Order 26.4b1. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All Residents on Hoyer Lift Transfers will have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. All residents on Hoyer Lift transfers were identified. Inservice by the D.O.N. on compliance with the P & P when performing Hoyer Lift Transfers. The following are in place for residents who are on Hoyer Lift transfers (1) physician□s order. (2) Task placed in point of care in PCC for aides to follow. (3) Task updated in Special instruction in EMR in PCC (4) Hoyer lift for transfer with 2 persons	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 689	Continued From page 8 assistance during [redacted]. [redacted]. A review of Resident #14's Plan of Care (POC), which was completed by their assigned [redacted], indicated that Resident #14 required [redacted] and a [redacted] for the [redacted]. A review of the facility-provided [redacted] revealed: On [redacted] at 10:35 AM, the [redacted] did not follow [redacted] policy and procedure and [redacted] Resident #14 independently, without an assistant. The resident [redacted] he MD was notified and ordered [redacted]. On 1/15/25 at 1:30 PM, the surveyor interviewed the [redacted] and [redacted] who confirmed the facility's policy included that all [redacted] required 2 staff members. The [redacted] further stated that the [redacted] was terminated because the [redacted] did not follow the facility policy. The surveyor attempted a phone interview with the [redacted] who had [redacted] Resident #14 [redacted] of a second staff member. The [redacted] did not return the surveyor's call.	F 689	assistance updated care plan. 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 systemic change? Charge nurses/ designee conducted random daily observation on how residents are being transferred via Hoyer Lift following the Policy and Procedure that is in place. Any identified non-compliance with be reported to Director of nursing /designee. Those nursing staff non-compliant with new policy and procedure will receive one-on-one counselling and reeducation that can escalate to termination. Results of the monthly audits will be submitted or reported to the monthly QAPI meeting until the goal of 100% compliance is achieved and the committee determines the problem is resolved. Results will be used for training and for system changes through the QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 689	Continued From page 9	F 689		

On 1/16/25 at 8:55 AM, the surveyor interviewed Resident #14's assigned US FOIA (b)(6) , who stated that all NJ Ex Order 26.4b1 required 2 staff assistants. The US FOIA further stated that the US FOIA (b) (6) educated all staff on safe transfers, which included the proper use of the NJ Ex Order 26.4b1 and two staff during those transfers.

On 1/16/25 at 9:00 AM, the surveyor interviewed Resident #14's assigned US FOIA (, who stated that she knew the resident well. She stated that she used a NJ Ex Order 26.4b1 when NJ Exec Order 26.4b1 the resident from the NJ Exec Order 26.4b1 and always obtained the NJ Ex Order 26.4b1 . The US FOIA (further stated that she had received in-services on safe transfers, which included ensuring there were always 2 CNAs when using the NJ Ex Order 26.4b1

On 1/16/25 at 9:10 AM, the surveyor interviewed the US FOIA (b)(6)), who stated that he was responsible for in-services for all staff on safe transfers. The US FOIA (b) provided copies of the in-services completed prior to and after NJ Ex Order 26.

A review of the facility's Mechanical Lift policy and procedure, reviewed 6/2024, indicated ... a mechanical lift allows a resident to be lifted and transferred with a minimum of physical effort. The Hoyer lift needs two caregivers to operate.

A review of the facility's Fall Investigation policy and procedure implemented 7/2018, reviewed 7/2024 indicated ...the objective of the Fall investigation was to analyze the cause of a fall and implement new initiatives to prevent future falls ... The rehab director will screen and give recommendations ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 689	Continued From page 10 No further information was provided by the facility.	F 689		
F 761 SS=D	NJAC 8:39-27.1 (a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined	F 761	1. How the corrective action will be accomplished for those residents found to	2/5/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 761	Continued From page 11 that the facility failed to a.)identify and dispose of expired biologicals in 2 of 3 medication carts, and b.) properly store an unopened biological in 1 of 3 medication carts inspected. This deficient practice was evidenced by the following: 1.) On 1/14/25 at 11:45 AM, in the presence of the US FOIA (b)(6)), the surveyor began the medication cart (med cart) inspection of cart A located on the third floor. During the inspection, the surveyor observed an opened bottle of NJ Ex Order 26.4b1 for Resident #56 that was stored in the manufacturer's packaging (box). The box for the NJ Ex Order 26.4b1 was labeled by the facility with an opened date of 11/26/24, and an expired date of 1/7/25. At that time, during an interview with the surveyor, the US FOIA confirmed that the NJ Ex Order 26.4b1 for Resident #56 was expired and that was the only supply of NJ Ex Order 26.4b1 in the med cart for administration to Resident #56. . The US FOIA stated that he did not administer the medication to the resident that day. At that time, the surveyor and the US FOI reviewed the electronic Medication Administration Record (eMAR) of Resident #56 together. The eMAR reflected that NJ Ex Order 26.4b1 was administered every night in NJ Ex Order 26.4b1, and was last administered on NJ Ex Order 26.4 at 8:00 PM. At that time, the US FOIA stated that the night shift nurse was responsible to ensure all the medications in the cart were not expired and that the nurses who administered the doses on NJ Ex Order 26.4b1, and	F 761	have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. The identified expired NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 have been discarded. The identified unopened NJ Ex Order 26.4b1 was placed in the refrigerator. Root cause: Failure to comply with the process in place. The last person who used a medication that was about to expire, disposed of the medication before the expired date, label the medications that required an opened date & discard date. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Director of Nursing have identified all residents who are on Insulin & eyedrops. Date opened & date of discard is indicated in the container of Insulin and eyedrops, monitored weekly by the DON/designee. Director of nursing have re-educated nurses on the following: (1) Nurse who opens the biological should indicate 2 dates: open date and date of discard	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 761	Continued From page 12 NJ Ex Order 26.4, should have checked the date before the administration of NJ Ex Order 26.4b1 to Resident #56. On 1/14/25 at 12:53 PM, in the presence of the US FOIA (b)(6) the surveyor began the med cart inspection on the first floor. During the inspection, the surveyor observed an opened bottle of NJ Ex Order 26.4b1) for Resident #35 that was stored in a box. The box for the NJ Ex Order 26 was labeled by the facility with an opened date of 12/7/24 and was not labeled with an expiration date. The surveyor and the US FOIA reviewed the box of NJ Ex Order 26 together. The NJ Ex Order 26.4 box reflected the manufacturer's specifications for storage that included the following: Refrigerate until first use. After first use, store at room temperature and discard after 28 days. At that time, the NJ Ex Or confirmed that the NJ Ex Order 26.4 for Resident #35 expired on 1/4/25, and that was the only opened NJ Ex Order 26 bottle in the cart for administration to Resident #35. The NJ Ex Or stated that she did not administer the medication to the resident that day. At that time, the surveyor and the US FOIA reviewed the eMAR of Resident #35 together. The eMAR reflected that NJ Ex Order 26 was administered every night in NJ Ex Order 26.4b1, and was last administered on NJ Ex Order 26.4 at 9:00 PM. At that time, the US FOIA stated that the night shift nurse was responsible to ensure all the medications in the cart were not expired. The nurses who administered the doses on NJ Ex Order 26.4b nd NJ Ex Order 26.4, should have checked the	F 761	(2) Nurse who last use the biological on date of discard will be responsible to discard the biological. (3) Night shift nurse is responsible for checking the medication cart to ensure that biologicals are dated accordingly and discarded appropriately. (4) Nurses who receive the biological is responsible to store the product in the refrigerator. (5) For new orders of biologicals, nurses who enter the new order in the EMR should have additional order to indicate frequency of when to dispose the medication. (e.g every 6wks to dispose latanoprost) and signing for it. 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 systemic change? Director of nursing or designee have identified the residents who are using biologicals (eyedrops and or insulin pens/vial). Audit will be done by DON or designee to monitor weekly if the plan in #3 are being followed. Any identified non-compliance will be reported to the Director of nursing /designee. Those nursing staff who are non-compliant with new policy and procedure will receive one-on-one counselling and reeducation that can escalate to termination. Results of the audits will be submitted or reported to the monthly QAPI meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 761	Continued From page 13 date before the administration of [NJ Ex Order 26] to Resident #35. The [US FOIA] added that checking for expiration was part of the standard of practice for medication administration and that an expired medication had reduced efficacy. The [US FOIA] added that she would remove the expired [NJ Ex Order 26] from the active inventory, inform the [US FOIA (b)] and call the pharmacy. 2.) On 1/14/25 at 12:58 PM, the surveyor continued to inspect the medication cart located on the first floor and observed an unopened/sealed bottle of [NJ Ex Order 26] for Resident #35. At that time, the [US FOIA] confirmed that the unopened bottle of [NJ Ex Order 26] should have been refrigerated as recommended by the manufacturer. The [US FOIA] stated that the nurse who received the medication should have refrigerated the unopened bottle of [NJ Ex Order 26] to avoid deterioration of effectiveness. On 1/14/25 at 1:07 PM, in the presence of the survey team, the US FOIA (b)(6) [redacted], the surveyor discussed the concerns with the expired [NJ Ex Order 26.4b1] and [NJ Ex Order 26] that Resident #56 and #35 received, was stored with the active inventory, unidentified, and the improper storage of the unopened/sealed [NJ Ex Order 26], for Resident #35, that was not refrigerated. On 1/15/25 at 1:34 PM, in the presence of the survey team, the [US FOIA (b)(6)], and the [US FOIA], the [US FOIA (b)] stated that nursing staff were re-educated on medication storage, a process was implemented wherein the last person who used a medication that was about to expire, disposed of the	F 761	until the goal of 100% compliance is achieved and the committee determines the problem is resolved. Results will be used for training and for system changes through the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 761	Continued From page 14 medication before the expired date, label medications that required an opened date and the discard date. All nurses on all shifts were expected to ensure proper labeling and storage of medications. A review of the facility provided "Medication Administration" policy dated/reviewed on 1/16/24 included that medications are administered as prescribed in accordance with good nursing principles ...The provided policy did not include a process to ensure medications administered were not expired. A review of the facility provided "Medical Storage" policy included that all medications must be clearly labeled with the resident's name, dosage instructions, and expiration dates. Medications should be stored at appropriate temperatures as specified by the manufacturer. No further information was provided.	F 761		
F 880 SS=D	NJAC 8:39-29.4 (c) (g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 880	Continued From page 15 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 880	Continued From page 16 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to use appropriate infection control practices specifically for 2 of 5 staff (US FOIA (b)(6)) and US FOIA (b)(6)) not following appropriate hand hygiene during meal service. The deficient practice was evidenced by the following: Reference: Hand hygiene should be performed immediately before touching a patient; before performing an aseptic task such as placing an indwelling device or handling invasive medical devices; before moving from work on a soiled body site to a clean body site on the same patient; after touching a patient or patient's surroundings; after contact with blood, body fluids, or contaminated surfaces.	F 880	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. The US FOIA (b)(6) observed was not allowed to return to Merry Heart. The US FOIA (b)(6) identified was re-educated on when to perform hand hygiene and this is required during meal service. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 880	Continued From page 17 CDC recommendations for Hand Hygiene: Updated February 27, 2024: https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html#cdc_clinical_safety_best_practices_recomm-recommendations On 1/10/25 at 12:10 PM, during a lunch meal dining observation in the 1st-floor dining room, the surveyor observed the lunch trays being distributed to the residents. The surveyor observed that there was no hand hygiene done by the US FOIA (b)(6) while assisting the residents with meal set up. On 1/10/25 at 12:35 PM, the surveyor observed the US FO apply soap to her hands, lather outside the stream of water for 2 seconds, and then put her hands under the stream of running water. The US FO turned off the faucet with her bare hands. On 1/10/25 at 12:40 PM, the surveyor observed the US FO apply soap to her hands and immediately place them under the stream of water without lathering outside the water. On 1/14/25 at 12:10 PM, during a lunch meal observation in the 1st-floor dining room, the surveyor observed the lunch trays being distributed to the residents. The surveyor observed that the US FO did not practice hand hygiene while assisting the residents with meal setup. On 1/14/25 at 12:33 PM, the surveyor observed the US FOIA applied soap to her hands and immediately placed them under the stream of water.	F 880	3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. All residents who need assistance with feeding were identified by the D.O.N. In-service provided by the D.O.N. on why, how and when to perform hand hygiene. DON/ designee will monitor weekly on the compliance of hand hygiene when assisting residents before, during & after meals. Director of nursing or designee will randomly observe lunch or dinner meals, weekly on different dining room areas, particularly hand hygiene between residents, during meal set up and while assisting residents to eat. 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 systemic change? Director of Nursing or Charge Nurse or designee will be assigned to check for compliance of nursing staff regarding hand hygiene between residents and during meal set up weekly. Any identified non-compliance with be reported to Director of nursing /designee. Those nursing staff who are non-compliant with new policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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) COMPLETION DATE
F 880	Continued From page 18 On 1/14/25 at 12:35 PM, the surveyor interviewed the [US FOI] who stated that she was not sure how long she should have washed her hands. She was not aware that she should lather for 20 seconds before placing her hands under the stream of water. On 1/14/25 at 12:39 PM, the [US FOIA (b)] was unavailable to be interviewed. On 1/14/25 at 12:49 PM, the above concerns were discussed with the [US FOIA (b)(6)]. The [US FOIA (b)] confirmed that staff were expected to perform hand hygiene before assisting residents with their meals. The [US FOIA (b)] further stated that staff should wash their hands for a full 20 seconds outside the stream of running water. NJAC 8:39-19.4 (a)	F 880	procedures will receive one-on-one counselling and reeducation that can escalate to termination. Results of the audits will be submitted or reported to the monthly QAPI meeting until the goal of 100% compliance is achieved and the committee determines the problem is resolved. Results will be used for training and for system changes through the QAPI committee.	

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
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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		
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: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the	S 560	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. Effective immediately, we will increase the number of CNAs on all shifts to meet the requirements of state and federal regulations. We have negotiated and	2/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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 560	Continued From page 1 Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth	S 560	signed a contract with an agency to fill gaps in the schedule until permanent employees can be hired and put in place. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. There is currently an ongoing CNA classes at this time and we will increase the number of CNA classes offered from 3 to 4 classes. We will continue with our immigration sponsorship program to recruit qualified CNA employees from abroad. We are in the process of reassessing our compensation rates for CNAs. The administrator or designee will conduct regular audits of staffing levels to ensure compliance with state and federal regulations. 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 systemic change? The administrator or designee will be responsible for audit compliance of staffing requirements per state and federal regulations. Staffing schedule will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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 560	Continued From page 2 place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports for the 2 weeks prior to survey for the dates of 12/22/2024 to 1/4/2025 for the 1/16/2025 Standard survey, the results are as follows: The facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -12/22/24 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -12/23/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.	S 560	monitored bi-weekly. Results of the audits will be submitted or reported to the monthly QAPI meeting until the goal of 100% compliance is achieved and the committee determines the problem is resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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 560	Continued From page 3 -12/24/24 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. -12/28/24 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs. -12/29/24 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. -1/1/25 had 8 CNAs for 88 residents on the day shift, required at least 11 CNAs. -1/3/25 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. -1/4/25 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. The Administrator and Director of Nrusing were made aware of the staffing results above.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus	S1680		2/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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
S1680	Continued From page 4 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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
S1680	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 12/22/2024 to 1/4/2025 for the 1/16/2025 Standard survey, it was determined that the facility failed to provide at least minimum staffing levels for 4 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 12/22/24 Required Staffing Hours: 270.75 -12/28/24 had 264 actual staffing hours, for a difference of -6.75 hours. The Administrator and Director of Nursing were made aware of the concerns above.	S1680	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. Effective immediately, we will increase the number of RNs on all shifts to meet the requirements of state and federal regulations. We have negotiated and signed a contract with an agency to fill gaps in the schedule until permanent employees can be hired and put in place. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061410	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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
S1680	Continued From page 6	S1680	We will continue with our immigration sponsorship program to recruit qualified RN employees from abroad. We are in the process of reassessing our compensation rates for nurses. We will conduct regular audits of staffing levels to ensure compliance with state and federal regulations. 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 systemic change? The administrator or designee will be responsible for audit compliance of staffing requirements per state and federal regulations. Staffing schedule will be monitored bi-weekly. Results of the audits will be submitted or reported to the monthly QAPI meeting until the goal of 100% compliance is achieved and the committee determines the problem is resolved.	

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
315057 Y1	A. Building B. Wing Y2	3/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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 F0550	Correction	ID Prefix F0583	Correction	ID Prefix F0689	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(h)(1)-(3)(i)(ii)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	02/05/2025	LSC	02/06/2025	LSC	02/05/2025
ID Prefix F0761	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	02/05/2025	LSC	01/31/2025	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	
1/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315057	A. Building B. Wing	3/27/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 02/05/2025	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
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

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	
1/16/2025	☐ 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 A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061410		3/27/2025

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

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 02/27/2025	ID Prefix S1680 Reg. # 8:39-25.2(b)(1)&(2) LSC	Correction Completed 02/27/2025	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	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

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	
1/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/15/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/15/25 and the facility was found to be in noncompliance 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. Merry Heart Nursing Home is a three-story building with a basement that was built in 2003. It is composed of Type II protected construction. The facility is divided into six - smoke zones. The generator powers 100 % of the building per the Maintenance Director. The current occupied beds are 94 of 114.	K 000		
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6.	K 311		2/20/25

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

Electronically Signed | 02/07/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 311	Continued From page 1 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure stairway fire rated door assemblies were equipped with a fire rating tag in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.1.3.2.1 (1 and 2). This deficient practice had the potential to affect all 94 residents at the facility. Findings include: Observations on 01/15/25 between 12:30 PM and 3:30 PM revealed one out of nine stairways exit access doors assemblies did not have a fire rating tag to indicate its fire rating. The US FOIA (b)(6) was present at the time of observation and confirmed the fire rating tag was not present on the door. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 311	Root cause: Failure to identify the absence of a fire rating tag in one out of the 9 stairways exit door 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Fire rating tag for one out of the 9 stairways exit access doors assembles did not have a fire tag. Vendor did all the fire door inspection on 2/6/2025. Quotation report of repairs and tagging will be available in one week. Completion of repairs will be 2/20/2025. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place systemic changes. Monthly inspection by the Maintenance Director/designee to ensure all doors have a fire rating tag. 4. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected & will not recur. What program will be put into place to monitor the continued effectiveness of the systemic change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 311	Continued From page 2	K 311	If a fire rating tag is not indicated in any of the exit access doors during the monthly inspection by the Maintenance Director/ designee, the Vendor will be called immediately by the Maintenance Director/designee for the tagging to be complied. In-service provided on 2/20/25 to the maintenance staff. Attached in service sheets. Results of the monthly audits will be submitted & reported to the monthly QAPI committee meeting, until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training & for system changes thru the QAPI committee.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in	K 345	1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice	1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 345	Continued From page 3 accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 94 residents at the facility. Findings include: A review of the facility's "Inspection and Testing Reports," dated 10/01/24, provided by the Maintenance Supervisor, revealed the report had no reference to a smoke detection sensitivity test. Observations on 01/15/25 from 12:30 PM to 3:30 PM revealed the smoke detectors were in the corridors 15-foot from the ends of the corridor and 30-foot on center and were located in all sleeping rooms. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	1/31/25, Panel device Maintenance & sensitivity report conducted and completed on 1/31/25 Root cause: Merry Heart was not provided with the result of the sensitivity test done by the vendor on 10/1/2024. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place systemic changes made to ensure the deficient practice will not recur? Sensitivity testing will be conducted by the Vendor yearly and report submitted to the Dir. of Maintenance. 4. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected & will not recur. What program will be put into place to monitor the continued effectiveness of the systemic change? Yearly audits will be done by the vendor and will provide the smoke detection sensitivity test report, to the maintenance director/designee. Maintenance Director/ designee will schedule the yearly smoke sensitivity test one month prior to the expiration of the annual testing, to ensure that the yearly smoke detection sensitivity test is complied. Results of the yearly audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 345	Continued From page 4	K 345	submitted & reported to the monthly QAPI committee meeting, until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training & for system changes thru the QAPI committee. In-service provided to the maintenance staff on the compliance of the smoke detection annual schedule on 1/31/25.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure all sprinklers used in the facility had at least six spare sprinkler heads in the spare	K 351	1. How corrective action will be accomplished for those residents found to have been affected by the deficient	2/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 351	Continued From page 5 sprinkler cabinet and that quick response sprinklers and standard response sprinklers were not in the same compartment in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (2010 Edition) Section 6.2.9.1. and 8.3.3.2. This deficient practice had the potential to affect all 94 residents at the facility. Findings include: Observations on 01/15/25 at 1:01 PM of the spare sprinkler cabinet in the sprinkler room revealed only one quick response sprinkler and no intermediate sprinklers were in the spare sprinkler cabinet. Observations on 01/15/25 at 1:35 PM revealed two quick response sprinklers and four standard response sprinklers were in the same compartment outside of the elevators on the 3rd floor. During an interview at the time of the observations, the US FOIA (b)(6) confirmed that only one quick response spare sprinkler and no intermediate spare sprinklers were present in the sprinkler cabinet. The US FOIA (b)(6) also confirmed two different types of sprinklers were used in one compartment. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 351	practice; Fire vendor replaced the standard response sprinklers to all Quick response sprinklers on 2/6/25. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur; The Maintenance Director / designee will conduct a monthly audit to ensure Quick response sprinklers are properly installed and in uniform in the same compartment. The fire vendor will conduct quarterly audits of the quick response sprinkler and submit the report to the maintenance director/designee. Malfunction of the quick response system will be called in by the Maintenance Director to the Vendor for immediate correction of the problem. Maintenance Staff Inservice on 2/6/25. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director / designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 351	Continued From page 6	K 351	maintain a monthly monitoring log to ensure that the intermediate sprinklers installed will be in place and function properly. Results of monthly audits by the Maintenance Director/designee will be reported to the Monthly QAPI Results of the yearly audits will be submitted to the QAPI committee meeting until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training and for system changes thru QAPI committee. 6 quick response head sprinklers in the spare sprinkler cabinet installed by the Vendor on 2/6/25.	
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 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		2/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 353	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the automatic sprinkler system's gauges were calibrated or replaced in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water Based Fire Protection Systems (2011 Edition) section 13.2.7.2. This deficient practice had the potential to affect all 94 residents at the facility. Findings include: Observations on 01/15/25 at 1:27 PM revealed the two gauges on the automatic sprinkler system in the sprinkler room and the two sprinkler gauges on the riser in stairway B third floor were last replaced on 01/2014 as noted on the gauges and there was no documented evidence the gauges had been tested in comparison with a calibrated gauge. This indicated it had been 11 years since the gauges were last replaced or tested not the required timeframe of five years. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the automatic sprinkler system gauges were not calibrated or replaced. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Fire vendor replaced the standard response sprinklers to all Quick response sprinklers on 2/6/2025.Date sprinkler system last checked, (NFPA25 Annual Check 9/9/2024), (Quarterly NFPA 25 12/23/2024) Date Completion date for the correction of K351: 2/6/2025Who provided system test- The fire Vendor. Water system supply source, Water Vendor, 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Maintenance Director / designee will conduct quarterly audit to ensure the automatic sprinkler systems and testing of the gauges in comparison with the calibrated gauge is completed. Any abnormal testing results of the gauges in comparison to the calibrated gauge will be replaced by the vendor according to the standards. The fire vendor will conduct quarterly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 353	Continued From page 8	K 353	audits of the quick response sprinkler and report findings to the maintenance director/ designee. 4. How will the facility monitor its corrective actions to ensure that the K353/deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? The Maintenance Director / designee will conduct quarterly audit to ensure the automatic sprinkler systems and testing of the gauges in comparison with the calibrated gauge is conducted. Any abnormal testing results of the gauges in comparison to the calibrated gauge will be replaced by the vendor according to the standards. The Maintenance Director / designee will maintain a monthly monitoring log to ensure that the intermediate sprinklers installed will be in place and function properly. Results of monthly audits by the Maintenance Director/designee will be reported to the Monthly QAPI Results of the yearly audits will be submitted to the QAPI committee meeting until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training and for system changes thru QAPI committee. Inservice to the maintenance staff completed on 2/6/25.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 361	Continued From page 9	K 361		
K 361 SS=F	Corridors - Areas Open to Corridor CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010 Edition) Section 5.2.1. This deficient practice had the potential to affect all 94 residents at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors had been inspected annually inspected. Observations on 01/15/25 from 12:30 PM to 3:30 PM of the facility's fire doors revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the US FOIA (b)(6) confirmed the fire doors had not been inspected annually.	K 361	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; The Vendor conducted the fire door inspection on 2/5/25 to 2/6/25 (attached). All Missing tag frames completed on 2/20/2025. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Maintenance director/designee will conduct monthly inspection to ensure fire doors inspection tags are in place. During the monthly inspection that a fire door tag is not in place the vendor will immediately be called by the Maintenance Director/designee for the tag to be placed.	2/20/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 361	Continued From page 10 NJAC 8:39-31.2(e) NFPA 80	K 361	Maintenance Director/designee will schedule one month prior to the annual fire door inspection due date, to ensure fire door tags are in place and door gap from top to bottom, left and right of the leaf door are in gap compliance. In-service to maintenance staff completed on 2/20/25. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? The maintenance director/designee will maintain a log for the monitoring & maintaining inspection tags are placed on the doors after completed inspections by the vendor. Results of monthly audits by the Maintenance Director/designee will be reported to the Monthly QAPI committee meeting until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training & for system changes through QAPI.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by	K 914		1/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 914	Continued From page 11 documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure electrical outlet testing was conducted annually in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.4.1.3. This deficient practice had the potential to affect all 94 residents at the facility. Findings include: A review of the facility's fire inspection binder provided by the US FOIA (b)(6) revealed no documented evidence the electrical outlet testing had been completed on the electrical outlets in the past 12 months. During an interview on 01/15/25 at 12:30 PM, the US FOIA (b)(6) stated the electrical outlet testing was not completed. NJAC 8:39-31.2(e) NFPA 99	K 914	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; Completed visual check, polarity, and sensitivity tests on each individual receptacle outlet in each resident's individual room with proper documentation. Report attached 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be K914 affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; The Maintenance Director / designee will conduct semi-annual check of receptacle	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 914	Continued From page 12	K 914	outlets in each of the residents room and all other outlets. 4. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? Electrical outlets testing will be conducted quarterly by the maintenance director/designee. Any electrical outlet/s that are defective will immediately be changed by the maintenance staff. The Maintenance Director / designee will maintain a quarterly monitoring log to ensure that the receptacle outlets in the resident□s room and all other outlets are in good physical/working condition. Results of the audits will be submitted &reported to the monthly QAPI committee meeting, until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training & for system changes thru the QAPI committee. In-service to maintenance staff completed 1/30/25.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918		2/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 918	Continued From page 13 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a load bank test was completed on the diesel-powered emergency generator once every 36 months; and failed to ensure the emergency generator was equipped with a remote manual stop station in accordance with	K 918	1. How corrective action will be accomplished for those residents found to have been affected by the deficient K918 practice; Vendor completed the generator for our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 918	Continued From page 14 NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.4.9. and 5.6.5.6. This deficient practice had the potential to affect all 94 residents at the facility. Findings include: A review of the facility's untitled generator reports dated for the years 2023 and 2024, provided by the facility revealed a three-year load bank test had not been completed for the diesel-powered emergency generator. An observation on 01/15/25 at 12:37 PM revealed the generator was not equipped with a remote manual stop station. During an interview on 01/15/25 at 12:45 PM, the US FOIA (b)(6) confirmed the three-year load bank test had not been completed on the diesel-powered emergency generator and the remote manual stop station was not present. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	load bank test on 1/20/2025. Vendor completed installation of the generator remote manual E-stop on 2/7/25. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Maintenance Director / designee will conduct monthly testing to ensure that the generator remote Manual E-stop is operating properly. The Maintenance Director/designee will schedule every 3 years load bank test with the vendor. 4. How the facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will not recur, what program will be put into place to monitor the continued effectiveness of the systemic change? If there is a failure in the load bank test and the manual E-stop operation of the generator, the maintenance director/designee will immediately call the vendor to correct the issue. The Maintenance Director / designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315057	A. BUILDING **01** B. WING _____	**01/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	**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) COMPLETION DATE
K 918	Continued From page 15	K 918	maintain weekly generator monitoring test log. Results of the audits will be submitted &reported to the monthly QAPI committee meeting, until the goal of 100% is achieved and the committee determines the problem is resolved. Results will be used for training & for system changes thru the QAPI committee. In-service to maintenance staff completed on 2/7/2025.	

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
315057 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	02/20/2025	LSC K0345	01/31/2025	LSC K0351	02/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	02/06/2025	LSC K0361	02/20/2025	LSC K0914	01/20/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	02/07/2025	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	
1/16/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO