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 01/05/2024

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 # NJ00167073, NJ00165021, NJ00163319, NJ00163360, NJ00160410 Survey Date: 01/05/24 Census: 90 Sample: 32 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	F 609		1/31/24

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

Electronically Signed | 01/25/2024

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F 609	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #165021 Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to report an injury of unknown origin to the New Jersey Department of Health NJDOH) promptly for 1 of 2 residents (Resident #99) reviewed for investigations and was evidenced by the following: A review of Resident #99's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to Ex.Order 26.4(b)(1) [redacted] A review of Resident 99's Admission Minimum Data Set (MDS), an assessment tool dated Ex.Order 26.4(b) [redacted], revealed that the resident had Ex.Order 26.4(b)(1) [redacted] Further review revealed that the resident required extensive assistance from one to two people for Activities of Daily Living (ADLs). A review of a nursing progress note dated Ex.Order 26.4(b)(1) [redacted] at 2:53 PM revealed on Ex.Order 26.4 [redacted] at 11:30 AM, the nurse was notified by physical therapy that while standing, the resident was observed to hav Ex.Order 26.4(b)(1) [redacted] Further review of the progress note revealed the doctor was notified	F 609	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #99, The resident no longer resides at Merry Heart. Reportable event record report was submitted to the New Jersey Department of Health & Senior Services and the Office of the Ombudsman on Ex.Order 26.4(b)(1) [redacted] by the DON. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents will have the potential to be affected by the deficient practice. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Mandatory Reporting guide for LTC facilities posted by the Assistant Administrator in the offices of the Director of Nursing, Assistant Administrator and Administrator.	

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F 609	Continued From page 2 and ordered Ex.Order 26.4(b)(1) . The staff assisted the resident into bed, and the nurse observed that the Ex.Order 26.4(b)(1) . A review of an Ex.Order 26.4(b)(1) dated Ex.Order 26.4 at 7:54 PM, signed by the MD at 10:29 PM, revealed that there was a complete Ex.Order 26.4(b)(1) with Ex.Order 26.4(b)(1) Further review of the Ex.Order 26 revealed there was Ex.Order 26.4(b)(1) A review of the nursing progress note dated Ex.Order 26.4 at 4:02 PM indicated that the resident was transferred to the hospital at 10:50 AM. A review of the Reportable Event Record Report revealed the facility reported Ex.Order 26.4(b)(1) to the New Jersey Department of Health on Ex.Order 26.4(b), eight days after the event happened. On 1/5/23 at 2:40 PM, the survey team met with the administration team. The Director of Nursing (DON) stated the facility should report injuries of unknown origin within 24 hours of the incident. Further, she stated that the facility was still investigating the incident, so the facility did not report the incident sooner. A review of the facility's policy labeled "Resident Abuse Prevention/Prohibition" with a reviewed date of 9/8/23, under the section heading of Reporting; in the case of an injury involving sutures or fracture of unknown origin, reports are filed with the Office of the Ombudsman and law enforcement immediately or within two hours. Further review revealed under section Reporting	F 609	The Assistant Administrator educated the Director of Nursing and Administrator on the time frame of reportable events. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator, Assistant Administrator/designee will continue to monitor daily for any unknown injury X 3 months. Reportable Event record/report form will be completed by the Administrator, Assistant Administrator/ designee and will report to the New Jersey Department of Health & Senior Services and the Office of the Ombudsman within 24 hours. In the absence of the Administrator, Assistant Administrator, the Director of Nursing/designee will report to the New Jersey Department of Health & Senior Services and the Office of the Ombudsman. Reportable incident audit results will be reported by the Assistant Administrator/designee to the QAPI monthly committee meeting until goal of 100% is achieved and the committee determines that the problem is resolved.	

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F 609	Continued From page 3 section C. that it is the responsibility of the Administrator to immediately (within one business day) report all actual or suspected incidents of abuse, neglect, or exploitation to the Department of Health. NJAC 8:39-4.1(a)(5)	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents it was determined that the facility failed to follow a physician's order (PO) for the application of Ex.Order [redacted] for 1 of 1resident reviewed, Resident #68. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally	F 658	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 68. Physicians Orders for Ex.Order 26.4(b)(1) to Ex.Order 26.4(b)(1) is in place. Root Cause: Failure of nursing staff to follow doctors order to verify placement of Ex.Order 26.4(b)(1). 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents will have the potential to be affected by the same deficient practice. Nurses on all 3 shifts will check and verify placement of Ex.Order 26.4(b)(1) when resident is	1/31/24

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F 658	Continued From page 4 authorized physician or dentist." On 1/2/24 at 10:41 AM, the surveyor observed Resident #68 in bed. The surveyor observed the resident's Ex.Order 26.4(b)(1) and there were Ex.Order 26.4(b)(1) in place. The surveyor observed a Ex.Order 26.4(b)(1) to the resident's Ex.Order 26.4(b)(1). On 1/4/24 at 9:55 AM, the surveyor asked the Registered Nurse to accompany her to resident #68's room. The surveyor observed the resident was in bed. The surveyor asked the RN if the resident had Ex.Order 26.4(b)(1) in place. The RN removed the residents blanket Ex.Order 26.4(b)(1) The RN and surveyor observed that the resident's Ex.Order 26.4(b)(1) The surveyor asked to see the residents Ex.Order 26.4 The RN lifted the residents Ex.Order 26.4(b)(1) and the surveyor observed that Ex.Order 26.4(b)(1). The RN stated that the resident was on a positioning program and that part of that program was to have Ex.Order 26.4(b)(1) on when in bed and to have Ex.Order 26.4(b)(1). The RN stated that it was the evening shifts responsibility to apply Ex.Order 26.4(b)(1) and the day shift to check and ensure they were in place. The RN found the Ex.Order 26.4(b)(1) in the resident's closet and put them on. On 1/4/24 at 10:06 AM, the Nursing Assistant who was assigned to provide care to Resident #68 came into the resident's room. The RN asked the NA if the resident had Ex.Order 26.4(b)(1) on when she provided care this morning. The NA replied that s/he did not have Ex.Order 26.4(b)(1) on yesterday or today and that she didn't know anything about Ex.Order 26.4(b)(1).	F 658	in bed during the day as per physician's order and sign the Treatment Administration Record. Nursing aides will make sure Ex.Order 26.4(b)(1) are in place before signing in the PointClickCare Tasks. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Physician orders indicate Ex.Order 26.4(b)(1). Director of Nursing / designee educated all nurses and C.N.A.s on: following doctors order, for proper application and placement of Ex.Order 26.4(b)(1) with return demonstration. Daily nursing 24-hour report by the nurses include compliance on the use of Ex.Order 2 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 during rounds at the beginning of each shift checks for the proper placement and application of Ex.Order 2 as per doctor's order. Any identified non-compliance by the charge nurse on each floor will be	

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F 658	Continued From page 5 Review of Resident #68's Admission Record revealed Resident #68 was admitted to the facility in Ex.Order 26.4(b)(1) and readmitted in Ex.Order 26.4(b)(1) with diagnoses which included, but not limited to, Ex.Order 26.4(b)(1) . A review of the Quarterly Minimum Data Set (MDS) an assessment tool dated Ex.Order 26.4(b)(1) reflected the Resident had a Brief Interview of Mental Status (BIMS) score of Ex.Order 26.4(b)(1) which indicated Resident #68 had Ex.Order 26.4(b)(1) . Section GG documented that Resident #68 had a Ex.Order 26.4(b)(1) and required maximum assistance with their personal hygiene. A review of the current Ex.Order 26.4(b)(1) Physician Order Summary Report reflected a Physician's order (PO) for the Positioning Program with interventions to apply Ex.Order 26.4(b)(1) while resident in bed and Ex.Order 26.4(b)(1) while in bed with an order date of Ex.Order 26.4(b)(1) . A review of the Treatment Administration Record (TAR) reflected the PO had been transcribed onto the TAR and signed by the nurses indicating the Ex.Order 26.4(b)(1) had been applied on Ex.Order 26.4 , Ex.Order 26.4 ,and Ex.Order 26.4 . On 1/4/24 at 1:38 PM, the survey team met with the Administration to discuss the above observations and concerns. The DON stated that Nurses and Nurse Aides were responsible for ensuring that physician's orders are followed and that the Ex.Order 26.4(b)(1) were in place as ordered. A review of the facility's "Nursing Assistant Job	F 658	reported to the Director of Nursing/designee. Director of Nursing/designee will re-educate / counsel nursing staff who are non-compliant with following the policy and procedure on heel boots placement when resident is in bed as ordered by the physician. Continued noncompliance of the nursing staff will result to termination. Director of Nursing will report/submit to the QAPI committee monthly meeting results of audits on, following doctors order of heel boots when in bed, until the goal of 100% compliance is achieved and Committee determines that the problem is resolved. Results will be used for training and for system changes through the QAPI committee.	

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F 658	Continued From page 6 Description and Performance Standards" undated, included ...the purpose of this position is to provide direct care to residents, under the supervision of a licensed nurse, in accordance with facility policies and procedures and report resident needs and concerns to a licensed nurse ....assist residents with Activities of Daily Living such as: daily mouth care, bath/shower functions, hair care, nail care, shaving and restorative/rehabilitation procedures.	F 658		
F 677 SS=D	NJAC 8:39-19.4 (a) (1) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to provide nail care to a resident who was dependent on the staff for Activities of daily living (ADL). This deficient practice was identified for 2 of 2 residents (Resident # 68 and #73) reviewed for ADL care. The deficient practice was evidenced by the following: 1.) On 12/27/23 at 11:50 AM, the surveyor observed Resident #68 in the small day room seated in a Ex.Order 26.4(b)(1). The surveyor observed the resident had Ex.Order 26.4(b)(1) and that the resident's fingernails were long, jagged, and soiled underneath.	F 677	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #68: nails clipped and filed. Resident #73: nails clipped and filed. Resident #73: shave completed. Root Cause: failure of staff to follow policy on ADL□s care. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents will be affected by the	1/31/24

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F 677	Continued From page 7 On 1/2/24 at 10:41 AM, the surveyor observed Resident #68 in bed with Ex.Order 26.4(b)(1), nails long, jagged and soiled. On 1/4/24 at 9:55 AM, the surveyor showed the Registered Nurse (RN #1) on the memory care unit the resident's nails and hands. RN #1 moved the resident's fingers which were pressing against their palms and acknowledged that the nails were soiled, long and jagged. RN #1 acknowledged that these jagged nails could have caused a break in the resident's skin integrity. On 1/4/24 at 10:06 AM, RN #1 asked the Nursing Assistant (NA) who was assigned to the care of Resident #68 when she had last cleaned, trimmed, and filed Resident #68's fingernails. The NA replied that the resident's hands were always closed but that she should have cleaned and trimmed them and would try to do it more often. RN#1 stated that the NA should be providing nail care daily. Review of Resident #68's Admission Record revealed Resident #68 was admitted to the facility in Ex.Order 26.4(b)(1) and readmitted in Ex.Order 26.4(b)(1) with diagnoses which included, but not limited to Ex.Order 26.4(b)(1) . A review of the Quarterly Minimum Data Set (MDS) an assessment tool dated Ex.Order 26.4(b), reflected the Resident had a Brief Interview of Mental Status (BIMS) score of Ex.Order 26.4(b)(1) which indicated Resident #68 had Ex.Order 26.4(b)(1) Section GG documented that Resident #68 had a Ex.Order 26.4(b)(1) and required	F 677	deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Nails will be clipped and filed during their scheduled shower days by the CNAs. Nail care added in PCC task for CNAs to sign when the task is completed. The nurse in charge of the resident in each floor will check skin and nail care while in the shower room during shower schedule. All male residents will be shaved during shower schedule and as needed by the CNA assigned. Shaving for male residents added in PCC task for CNAs to sign when task is completed. The nurse in charge of the resident in each floor will check if shaving was completed. All scheduled shower during 7-3 shift will be checked by 3-11 nurses on each floors to ensure that nail care was provided. All scheduled shower during 3-11 shift will be checked by 11-7 shift nurses on all floors to ensure that nail care was provided. 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?	

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F 677	Continued From page 8 maximum assistance with their personal hygiene. 2.) On 12/27/23 at 11:51 AM, the surveyor observed Resident #73 seated in a wheelchair in the day room. The surveyor observed the resident to be unshaven with long facial hair, and their fingernails long, jagged, and soiled underneath. On 1/3/24 at 11:46 AM, the surveyor interviewed Resident #73 in their room. The surveyor asked the resident if s/he preferred facial hair. Resident #73 felt their face and neck with their hands and replied, "no I don't like it. It bothers me." Resident #73 further stated that s/he would prefer their nails to be cleaned and trimmed. On 1/3/24 at 11:51 AM, the surveyor interviewed RN #2 who stated that the Nursing Assistants were responsible for shaving the residents and for providing nail care. RN#2 acknowledged that Resident #73's facial hair was long and unkept and that it appeared the resident had not been shaved in quite a while. RN#2 further stated that it appeared as though the Resident had not received nail care recently, as the resident's nails were soilded, long and jagged. On 1/3/24 at 12:00 PM, RN#2 asked the NA when she had last shaved Resident #73. The NA replied, "Yesterday." RN#2 stated that the NA could not possibly have shaved the resident yesterday as the facial hair was too long. The NA replied that she was sorry and didn't remember when she last shaved the resident because s/he Ex.Order 26.4(b)(1) The surveyor asked RN#2 if the NA ever reported this Ex.Order 26.4(b)(1) to her. RN#2 replied, "no" and further stated that she was not aware that Resident #73 had any Ex.Order 26.4(b)(1) of	F 677	Director of Nursing /designee will conduct nail care check and shaving of three male residents per floor weekly for compliance. Nurses on each floor will include in the 24-hour report name of residents who were shaved and nail care on their shift. Any identified non-compliance will be reported by the charge nurse on each floor to the Director of Nursing/designee. Director of Nursing/designee will provide one on one counseling, re-education, and disciplinary action to nursing staff who are non-compliant with the implemented policy and procedures. The Director of Nursing will submit results of the audits on nail care and shaving 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 thru the QAPI committee.	

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F 677	Continued From page 9	F 677		

Ex.Order 26.4(b)(1) [redacted] care. RN#2 showed the NA Resident #73's nails. The NA acknowledged that the nails were long, jagged, and soiled underneath. The NA stated she was sorry and should have cleaned, trimmed, and filed Resident #73's nails.

A review of the resident's Admission Record reflected Resident #73 had diagnoses that included but were not limited to, Ex.Order 26.4(b)(1) [redacted]

A review of the Quarterly Minimum Data Set (MDS) dated Ex.Order 26.4(b)(1) [redacted], revealed that Resident #73 had a BIMS score Ex.Order 26.4(b) [redacted] of 15 which indicated the resident had Ex.Order 26.4(b)(1) [redacted]. Section E of the MDS revealed that the resident did not have any Ex.Order 26.4(b)(1) [redacted]. Section GG assessed the resident required limited assistance of one staff member for personal hygiene.

On 1/4/24 at 1:38 PM, the survey team met with the Administration to discuss the above observations and concerns. The DON stated that the Nurse Aides were responsible for providing nail care daily and as needed and that Resident #73 should be shaved daily. The DON further stated that if a resident refused care the Aides should notify the nurse.

A review of the facility's "Nursing Assistant Job Description and Performance Standards" undated, included ...the purpose of this position is to provide direct care to residents, under the supervision of a licensed nurse, in accordance

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F 677	Continued From page 10 with facility policies and procedures and report resident needs and concerns to a licensed nurse ....assist residents with Activities of Daily Living such as: daily mouth care, bath/shower functions, hair care, nail care, shaving and restorative/rehabilitation procedures. NJAC 8:39-27.1(a), 27.2(g)	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined that the facility failed to change the [redacted] as directed by the Physician order and follow the facility policy. This deficient practice was identified for 1 of 1 resident (resident #40), which was reviewed for [redacted] This deficient practice was evidenced by the following: On 12/27/23 at 11:00 am, the surveyor entered resident's #40 room and observed [redacted]	F 695	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; [redacted] order for Resident #40 discontinued. Root Cause: Failure of the nurses to follow doctors order to change [redacted] y and signing the Treatment Administration Record without changing. 2. How the facility will identify other	1/31/24

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 01/05/2024

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

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F 695	Continued From page 11 Ex.Order 26.4(b)(1)) and a plastic drawstring bag which was dated 10/23/23 on the outside of the bag. The plastic drawstring bag was hung from the Ex.Order 26.4(b)(1) and inside the plastic drawstring bag was a nasal cannula tubing with the date of 10/22/23. On 12/28/23 at 12:00pm, the surveyor entered resident's #40 room and observed a plastic drawstring bag with the date of 10/23/23 on the outside of the bag. The plastic drawstring bag was on the Ex.Order 26.4(b)(1) and was hung from the Ex.Order 26.4(b)(1) Inside the plastic drawstring bag was a nasal cannula tubing dated 10/22/23. The resident was observed in bed without Ex.Order 26.4(b) and appeared comfortable. The surveyor reviewed the medical record of resident #40. Review of the Admission Record (an admission summary) reflected that resident #40 was admitted to the facility with diagnoses which included but are not limited to: Ex.Order 26.4(b)(1) [redacted]). Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. Revealed that resident #40, had a Brief Interview for Mental Status (a tool used to identify the cognitive condition) scored a	F 695	residents having the potential to be affected by the same deficient practice. All residents on oxygen have the potential to be affected by the deficient practice. All residents with oxygen will be checked by the morning and evening shift nurses indicating that the tubing was changed and dated correctly, weekly x 3 months. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Nurses on 7-3 and 3-11 shift, will check weekly on Sundays to ensure oxygen tubing's are replaced as scheduled. The Director of Nursing counseled and re-educated the two Nurses involved, on not following doctors order to change oxygen tubing weekly and signing the Treatment Administration Record without changing. The Director of Nursing have in-serviced all nurses on the new policy on verifying the weekly changing of the oxygen tubing, following doctors' orders, and not signing the Treatment Administration Record if the tubing change was not done. 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?	

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F 695	Continued From page 12 Ex.Order 26 of 15, which indicated that the resident was Ex.Order 26.4(b)(1) . In section (I) of the MDS active diseases number Ex.Order 26.4(b)(1) during the observation period (a time period which the resident's condition or status is captured by the MDS assessment). In section O of the MDS (Special Treatments, Procedures and Program) number Ex.Order 26.4(b) section titled Respiratory Treatments. Ex.Order 26.4(b)(1) is not checked for the following continuous (receiving Ex.Order 26.4(b)(1) continuously), intermittent (not continuous Ex.Order 26.4(b)(1), Ex.Order 26.4(b) administered for symptom relief), high concentration (Ex.Order 26.4(b)(1) that delivers a Ex.Order 26.4(b)(1)) while a resident. This section indicated that resident #40 was not on Ex.Order 26.4(b)(1) during the observation period. A review of the Ex.Order 26.4(b)(1) Order Summary Report revealed a Physician Order dated Ex.Order 26.4(b)(1) for Ex.Order 26.4(b)(1) every 1 hours as needed. Further review of the Physician Order also revealed a Physician order dated Ex.Order 26.4(b) to "CHANGE" and date Ex.Order 26.4(b)(1) weekly on Sunday 11-7 shift every night shift every Sun (Sunday) for as per protocol with a physician order. A review of the Ex.Order 26.4(b)(1) Treatment Administration Record revealed the order to	F 695	Director of Nursing /designee will conduct weekly check of all residents with oxygen on all 3 floors, following doctor's order, proper changing and dating of oxygen tubing's as scheduled, for 3 months. Any identified non-compliance will be reported by the floor nurse who identified the deficient practice to the Director of Nursing /designee. Director of Nursing/designee will educate all nurses on the new policy and procedure on, following doctors order and on the weekly oxygen tubing changes. The Director of Nursing/designee will submit results of audits on the compliance of, following doctor's order on weekly oxygen tubings changes with appropriate date of when it was changed, to the QAPI committee monthly 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.	

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F 695		F 695		

Continued From page 13

change and date Ex.Order 26.4(b)(1) weekly on Sunday 11-7 shift every night shift every Sun (Sunday) for as per protocol. Indicated that the physician order was signed as completed on Ex.Order 26.4(b)(1) and Ex.Order 26.4(b)(1)

A review of the Ex.Order 26.4(b)(1) Order Summary Report (OSR) revealed a Physician Order dated Ex.Order 26.4(b)(1) for Ex.Order 26.4(b)(1) every 1 hours as needed. Further review of the Order Summary Report revealed a Physician Order dated Ex.Order 26.4(b)(1) to "CHANGE" and date plastic drawstring bag for Ex.Order 26.4(b)(1) weekly on Sunday, 11-7 shift DATE AND INITIAL EACH BAG. Every night shift every Sun (Sunday).

A review of the Ex.Order 26.4(b)(1) Treatment Administration Record revealed the order to change and date plastic drawstring bag for Ex.Order 26.4(b)(1) weekly on Sunday, 11-7 shift had been signed which indicated as completed on Ex.Order 26.4(b)(1); and Ex.Order 26.4(b)(1).

On 12/29/23 at 12:00pm the surveyor interviewed the Registered Nurse (RN) (floor nurse), who stated that al Ex.Order 26.4(b)(1) is changed weekly and as needed. This surveyor showed her the plastic drawstring bag which was dated 10/23/23 and asked should the Ex.Order 26.4(b)(1) have been changed, and the Registered Nurse stated that resident #40 does not use Ex.Order 26.4(b)(1) The surveyor responded should the Ex.Order 26.4(b)(1) have been discarded since she is not wearing Ex.Order 26.4(b)(1) all the time and the Registered Nurse responded yes.

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F 695	Continued From page 14 On 12/29/23 at 12:25pm, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that resident #40 has never worn [redacted] Review of the facility's policy "Oxygen, Administration of" which was implemented 3/2010 and reviewed 12/12/23 revealed under the section face mask administration, #24 for intermittent therapy, wash cannula, mask, tubing, and catheter weekly with mild soap, rinsing with warm water. Allow to air dry on paper toweling or hang on towel rack and #25, for continuous therapy, replace cannula, mask, tubing, and catheter weekly. NJAC 8:39-11.2(b)	F 695		
F 728 SS=E	Facility Hiring and Use of Nurse Aide CFR(s): 483.35(d)(1)-(3) §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees.	F 728		2/16/24

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F 728	Continued From page 15 A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b). This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility allowed 2 of 4 Non-Certified Nursing Aides (NA) to continue working as an NA after the specified 120 days. This deficient practice was identified during NA review. This deficient practice was evidenced by the following: Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: Facilities are advised as follows: I. TNAs (Temporary Nursing Assistant) A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the	F 728	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice; NA #1 will not work until they have passed the certification. NA #2 will not work until they have passed the certification. All Nursing Aides will not be scheduled to work beyond 120 days and if they failed to pass the certification exam. The Administrator/designee educated the Nursing Staffing Coordinator and Human Resource Team on the ratio of the total number of Certified Nursing Aide (C.N.A.)	

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F 728	Continued From page 16 State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE (Public Health Emergency), whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP (Nurse Aide Training and Competency Evaluation Program) program and pass the exams. II. Nurse Aides Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 12/27/23 at 10:47 AM, during entrance conference the Director of Nursing (DON) stated that they did not have any Nursing Aides (NAs) working past their 120 days. The DON was given the "Nursing Staffing Reports" to be completed for the two weeks of staffing prior to the recertification survey. On 1/2/24 at 11:00 AM, the surveyor met with the	F 728	to every eight residents for the day shift. There should be one direct care staff member (C.N.A.) to every 10 residents for the evening shift. There should be one direct care staff (C.N.A.) to every 14 residents during the night shift. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents will be affected by deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? All Nursing Aides will not be scheduled to work beyond 120 days and if they failed to pass the certification exam. The Human Resources Department, will assist with the recruitment of Certified Nursing Aides and will utilize healthcare staffing agencies, increase our visibility and budget for our current employment recruiting websites, and conduct an annual job fair specifically for certified nursing aides. We will continue our employment sponsorships for both nurses and nursing aides. We will conduct a minimum of 2-3 certified nursing aides classes annually. The Nursing Staffing Coordinator will submit the daily staffing schedule to the Director of Nursing/designee and Human Resources Staff ahead of the schedule	

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	315057	A. BUILDING _____ B. WING _____	C 01/05/2024

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F 728	Continued From page 17 DON to inquire about the "Nursing Staff Reports" which did not list any NAs or Certified Aides in training. The DON apologized and stated that the Staffing Human Resource assistant (SHRA)completed them incorrectly. The surveyor requested a list of NAs along with their dates of hire (DOH), and proof of their enrollment in a Certified Nursing Aide (CNA) school. On 1/3/24 at 10:27 AM, the surveyor interviewed the SHRA who stated that the facility does not use NAs for staffing. The surveyor asked for a list of NAs along with their DOH, and proof of their enrollment in a CNA school. On 1/3/24 at 11:00 AM, the DON provided the surveyor with a list of NAs which included the Dates of hire (DOH). The DON stated that Human Resources was responsible for maintaining the records for NAs. On 1/3/24 at 12:00 PM, the surveyor interviewed RN#2 who stated that that NA#1 had her own assignment and was not working alongside or sharing an assignment with the Certified Nursing Assistant. On 1/3/24 at that same time the surveyor interviewed NA#1 who stated that she was working alone, had a full assignment and was still in training. The surveyor asked NA#1 when she started working at the facility. NA#1 replied that she was still in training. The surveyor asked her the date of hire and if she had taken the certification test. NA #1 did not respond. Review of the NA list provided by the facility revealed the following:	F 728	date for review to ensure proper staffing levels as required by the minimum staffing requirements for nursing homes. The Human Resources Director/designee and the Director of Nursing/designee will conduct and review staff qualifications before the name of the employee is on the work schedule. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Any identified non-compliance on scheduling nursing aides beyond 120 days will be investigated by the Human Resources Director. The Staffing Coordinator and other staff members involved, will receive one-on-one counseling and re-education. Results of the audits of the eligibility of the Nursing Aides to work by the Staffing Coordinator and the Human Resources Director/designee will be reported to the QAPI monthly committee meeting until the goal of 100% compliance is achieved and the committee determines that the problem is resolved.	

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	315057	A. BUILDING _____ B. WING _____	C 01/05/2024

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F 728	Continued From page 18	F 728		

NA#1, Date of Hire (DOH) [redacted] 120 days from date of hire: [redacted]
NA#2, DOH [redacted] 120 days from date of hire: [redacted]
The surveyor requested the program completion dates several times however the facility did not provide this information to the survey team.

On 1/5/24 at 11:18 AM, during an interview the DON stated that she was aware that NAs should be certified within 120 days of hire and that the Staffing Coordinator/HR and LNHA would have to address this concern. The surveyor requested a copy of the formal job offer letters to the above-listed NAs. The DON stated that she would ask HR for a copy of them.

On 1/5/24 at 11:50 AM, during an interview the HR assistant/ staffing coordinator stated that she does not include NAs in her staffing, they only shadow the Certified Nursing Assistants. The surveyor told the HR staffing coordinator that on 1/3/24 the surveyor observed that CNA #1 had a full assignment (assignment B) on the memory care unit which included 7 Residents. The HR staffing coordinator replied, "I only use NAs if I don't have enough CNAs." The HR assistant/staffing coordinator further stated that she was aware of the 1CNA to 8 resident ratio. The surveyor requested a copy of the document verifying NA enrollment in a CNA training class and the date the Certification Test is scheduled. The HR/staffing assistant replied she is unable to provide the surveyor with the requested documents. She only received confirmation once the NAs have taken the exam.

On 1/5/24 at 2:22 PM, during an interview on the 3rd floor, NA#2 stated that she started working at

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	315057	A. BUILDING _____ B. WING _____	C 01/05/2024

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F 728	Continued From page 19 the facility in Ex.Order 26.4(b)(1) and was enrolled in a training class to become a Certified Nursing Assistant. She further stated that she was aware that she should not have an assignment, but she was given a full assignment regularly. On 1/5/24 at 1:39 PM, the LNHA acknowledged that NAs should be certified within 120 days of hire. Review of the Facility provided "Job Description and Performance Standards" for Non-Certified Nursing Assistants reflected ...Qualifications ...Must be currently employed less than 4 months and currently enrolled in a state approved Nurse Aide in Long Term Care Facilities training course and scheduled to complete the competency evaluation program (skills and written/oral exam) within 4 months of employment. No additional information was provided to the survey team. N.J.A.C. 8:39-43.10	F 728		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		1/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 20 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to store, label, and date potentially hazardous foods to prevent food-borne illnesses. This deficient practice was evidenced by the following: On 12/27/23 at 10:13 AM, the surveyor, in the presence of the Assistant Supervisor of Dietary (ASD), toured the kitchen and observed the following: 1. In the walk-in freezer, an opened box of fully cooked flame-broiled beef patties in a plastic bag that was opened to air and was not labeled or dated as to when they were opened. 2. In the walk-in freezer, there were 20 beef patties in a plastic bag in a box labeled for an artificial sweetener. The plastic bag or the box was not labeled or dated. 3. In the walk-in freezer, there was a plastic bag with 12 chicken patties identified by the ASD that were not labeled or dated. 4. In the walk-in refrigerator there was a plastic	F 812	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Each dietary staff had been trained on the importance of dating food products after opening and following manufacturer's instructions. All dietary staff have been educated by the Assistant Administrator on the importance of dating when opening food container and labeling when this was opened. Root cause: Failure of staff to follow policies on Food labeling and dating. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All the residents have the potential to be affected by the deficient practice. Daily check by the Food Service/designee of the freezer for proper labeling & dating of food products. Opened food products not labelled or dated will be discarded. 3. Address what measures will be put into	

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F 812	Continued From page 21 resealable bag with 11 hotdogs dated 11/29/23. The ASD stated that if eaten, someone could get sick and removed the hotdogs. On 12/29/23 at 1:19 PM, the surveyor met with the contracted dietitian, who stated that she works 10-15 hours per week and provided supervision of the food service staff. She stated that the facility labeling policy is after five days open, the staff should discard from the refrigerator. The food in the freezer should be labeled and dated when opened. On 1/4/23 at 1:38 PM, the survey team met with the administration and was informed of the findings. A review of the facility's policy "Storing and Dating of Food Policy" with a reviewed date of 2/23/22 indicated to date food when they are received with the received date. Label opened or site-prepared ready-to-eat potentially hazardous foods that are held for more than 24 hours, with the discard date after the 5th day or per manufacturer's guideline indicated on the package [...] Store food in original packaging[...] label the new container with the name of the food and the original use by or expiration date. NJAC8:39-17.2(g)	F 812	place or systemic changes made to ensure that the deficient practice will not recur. Each staff member was educated by the Assistant Administrator/ designee on the policies of dating food products after opening and following manufacturers instructions. Daily spot check by Registered Dietitian/Food & Nutrition Service Director/ designee of the freezer to check appropriate labeling and dating of food products after opening the container. Poster in placed outside and inside the freezer door and the shelves inside the freezer reminding staff to write the date when a package or container is opened and date to be discarded. Food and Nutrition Services staff was provided with pre-printed labels to write the date of food products was opened and the date to be discarded. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed. Food service Director/ designee will conduct daily audit of all freezer to ensure proper labeling of all food containers/packages. Any identified non-compliance 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 _____ B. WING _____	C 01/05/2024

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

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F 812	Continued From page 22	F 812	investigated by Food & Services Director/designee and staff member will receive one-on-one counseling and re-education and can escalate to termination. Results of the audits by the Registered Dietitian/Food Service Director/designee will be reported to the QAPI monthly committee meeting until the goal of 100% compliance is achieved and the committee determines that 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
	061410	A. BUILDING: _____ B. WING _____	C 01/05/2024

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

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S 000	Initial Comments Complaint # NJ00167073, NJ00165021, NJ00163319, NJ00163360, NJ00160410 The facility is 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00165021 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: 1. Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance	S 560	1. How any corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Merry Heart Staffing Coordinator was educated by the Human Resources Director/designee, on the following: 1. Ratio of the total number of Certified Nurse Aides for each shift as per minimum staffing requirement for nursing homes. One Certified Nurse Aide (C.N.A.) to every	2/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRY HEART NURSING HOME	200 RT 10 WEST SUCCASUNNA, NJ 07876

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S 560	Continued From page 1 with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift; One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 05/21/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -05/21/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -05/21/23 had 6 total staff for 93 residents on the overnight shift, required at least 7 total staff. -05/25/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/26/23 had 7 CNAs for 93 residents on the day	S 560	eight residents for the day shift. One direct care staff member (C.N.A.s) to every 10 residents for the evening shift. One direct care staff (C.N.A.s) to every 14 residents for the night shift. 2. All Nursing Aides will not be scheduled to work beyond 120 days and if they failed to pass the certification exam. Human Resources will not allow scheduling of Nursing Aides not until a state-approved certification is obtained. Root Causes: 1. Nationwide shortage of Certified Nursing Aides. 2. Lack of availability of both NJ PSI testing times and testing sites. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents may 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? The Human Resources Department will use best practices and strategies with the recruitment of Certified Nursing Aides. The Human Resources Department will utilize staffing agencies, employment websites, quarterly job fairs, continuous employment sponsorship, 3 CNA classes	

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 01/05/2024

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

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S 560	Continued From page 2 shift, required at least 12 CNAs. -05/27/23 had 8 CNAs for 92 residents on the day shift, required at least 11 CNAs. -05/27/23 had 6 total staff for 92 residents on the overnight shift, required at least 7 total staff. -05/28/23 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -05/29/23 had 8 CNAs for 89 residents on the day shift, required at least 11 CNAs. -05/31/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -06/01/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. -06/02/23 had 7 CNAs for 89 residents on the day shift, required at least 11 CNAs. -06/03/23 had 9 CNAs for 89 residents on the day shift, required at least 11 CNAs. 2. For the 2 weeks of staffing prior to survey from 12/10/2023 to 12/23/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/10/23 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -12/11/23 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/12/23 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs.	S 560	annually. 4. How do we monitor that the solutions are sustained? Merry Heart Staffing coordinator will submit daily nursing staffing schedule to the Administrator/designee and Director of Nursing one week ahead of the schedule date for review and proper counting and staffing level as required by the minimum staffing requirements for nursing homes. Any identified noncompliance will be investigated by the Administrator and the Director of Nursing/designee. Results of the audits or investigations of staffing requirement will be reported by the Merry Heart Staffing Coordinator to the QAPI monthly committee meeting until the goal of 100% compliance is achieved and the committee determines that the problem is resolved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 -12/13/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/14/23 had 6 CNAs for 93 residents on the day shift, required at least 12 CNAs. -12/15/23 had 6 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/16/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/17/23 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/18/23 had 5 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/19/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/20/23 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -12/21/23 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -12/22/23 had 7 CNAs for 93 residents on the day shift, required at least 12 CNAs -12/23/23 had 7 CNAs for 90 residents on the day shift, required at least 11 CNAs. On 01/05/24 at 11:50 AM, during an interview with the surveyor, the Human Resources assistant stated that they were aware of the staffing ratio requirements. Shift."12/31/20 and reviewed on 11/01/23 reflected the following:	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 "Policy: This facility shall employ staff in sufficient number and with sufficient ability and training to provide the basic resident care, assistance, and supervision required, based on the facility's assessment of acuity (acuteness or severity) of resident's needs." "Staffing requirements: One CNA to every 8 residents for day shift." "One direct care staff member (RN, LPN, or CNA) to q (every) 10 residents for the 3-11." "One direct care staff member (RN, LPN or CNA) to every 14 residents for 11-7 shift."	S 560		

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	2/23/2024

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 01/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
1/5/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315057 Y1	A. Building B. Wing Y2	2/23/2024 Y3

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

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ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0609	Correction	ID Prefix	F0658	Correction	ID Prefix	F0677	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.24(a)(2)	Completed
LSC		01/31/2024	LSC		01/31/2024	LSC		01/31/2024
ID Prefix	F0695	Correction	ID Prefix	F0728	Correction	ID Prefix	F0812	Correction
Reg. #	483.25(i)	Completed	Reg. #	483.35(d)(1)-(3)	Completed	Reg. #	483.60(i)(1)(2)	Completed
LSC		01/31/2024	LSC		01/31/2024	LSC		01/31/2024
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/5/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061410	A. Building B. Wing	2/23/2024

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 01/31/2024	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	
1/5/2024	☐ 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 _____	**01/05/2024**

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 This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/03/2024 and Merry Heart Nursing Home was found to be in compliance 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 Occupancies. Merry Heart Nursing Home is a three-story Type II (111) constrution that was built in 2001. The facility is fully sprinklered with smoke detection in resident rooms, corridor detection, and spaces opened to the corridor. The facility has 7 smoke compartments.	K 000		

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

Electronically Signed | 01/22/2024

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