STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315001	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merwick Care & Rehab Center, LLC	100 Plainsboro Road Plainsboro, NJ 08536

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: 3015011Based on interviews, record review, and review of other pertinent facility documents it was determined that the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice by a) discharging a resident with a midline catheter (long, flexible catheter inserted into larger veins of the upper arm) in place without a physician order (PO) to do so; and b) removing a resident's midline catheter after the resident was discharged at the resident's home without a PO to do so. This deficient practice was identified for 1 out of 3 residents reviewed for the discharge process (Resident #2). 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 registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Resident #2 was no longer at the facility. The closed medical record for Resident #2 was reviewed. A review of the admission record face sheet for Resident #2 revealed that the resident was admitted to the facility with diagnoses including but not limited to: pleural effusion (collection of fluid around the lungs), heart failure (heart muscle not pumping blood as well as it should), type 2 diabetes mellitus (body cannot use insulin correctly causing sugar build-up in the blood), malignant neoplasm of an unspecified site of unspecified female breast (abnormal growth of cells that are cancerous), and elevated white blood cell count (increased number of blood cells that help fight infection, aid in healing, and assist in recovery from disease). A review of the discharge Minimum Data Set (MDS) an assessment tool dated 03/20/2026, revealed that Resident #2 had a Brief Interview for Mental Status Score of 15 out of 15, which indicated that the resident's cognition was intact. A review of the Infectious Disease Nurse Practitioner Note with an effective date of 03/11/2026 at 10:49 AM, revealed a recommendation that Resident #2 start Vancomycin (antibiotic used to treat bacterial infections that are resistant to other antibiotics) 750 milligrams (MG) intravenously (IV) daily and ertapenem (antibiotic used to treat bacterial infections) 1 gram (GM) IV daily for 7 days for a sacral (triangular bone at the base of the spine) pressure ulcer which was covered with slough (dead tissue within a wound) and surrounded by cellulitis (infection of the skin and the soft tissues underneath). A review of the health status note with an effective date of 03/11/2026 at 2:30 PM, revealed that Resident #2 was to have a midline inserted by an outside company. The PN further revealed that the midline was for antibiotic therapy with vancomycin and ertapenem. Review of the Order Summary Report (OSR) for Resident #2 revealed the following physician orders (POs): Please place midline. The order date was 03/11/2026. Ertapenem sodium injection solution 1GM, IV one time for wound infection once medication arrives from the pharmacy. The order date was 03/11/2026. The start date was 03/12/2026. Ertapenem sodium Injection solution 1GM, IV every 24 hours for cellulitis for seven days. The order date was 03/11/2026. Vancomycin IV solution 750 MG per 150 ML one time a day for seven days for cellulitis. The order date was 03/11/2026. The start order date was 03/11/2026. A (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of the Medication Administration Record (MAR) for Resident #2 revealed that the resident received the prescribed dose of ertapenem on 03/12/2026 at 9:27 AM, and 7:39PM, on 03/13/2026, 03/14/2026, 03/15/2026, 03/16/2026, and 03/17/2026. The MAR further revealed that Resident #2 received the prescribed dose of vancomycin on 03/11/2026, 03/12/2026, 03/13/2026, 03/14/2026, 03/15/2026, 03/16/2026, and 03/17/2026. A discharge note written by physician (PHY) #1, dated 03/20/2026 at 6:31 AM, was reviewed. The PN revealed that Resident #2's scheduled discharge date was 03/20/2026. The PN further revealed that the resident's prescriptions were written, and discharge instructions reviewed with the resident. Further review of the OSR revealed an order that Resident #2 could be discharged home on [DATE]. The order date was 03/20/2026. The order start date was 03/20/2026. The OSR did not reveal an order for the resident's midline to remain in place or an order to remove the midline. A late entry PN written by Licensed Practical Nurse (LPN) #1, dated 03/20/2026 at 2:27 PM, and entered into the facility electronic medical record on 03/21/2026 at 2:37 PM, was reviewed. The PN revealed that a midline catheter was removed from Resident #2's right upper extremity without complication and the site was assessed and found to be clean, dry, and intact. The PN further revealed that Resident #2 was prepared for discharge and left the facility at 2:45 PM, via medical transport and was accompanied by a family member. An interview was conducted with LPN #1 on 05/19/2026 at 4:27 PM. LPN #1 stated that she was the nurse who discharged Resident #2 from the facility on 03/20/2026. LPN #1 stated that it was the usual practice to do a head-to-toe assessment on residents prior to discharging them. LPN #1 stated that she did not perform a head-to-toe assessment on Resident #2 prior to discharging the resident. LPN #1 stated that she did not know that Resident #2 had a midline in place when they were discharged . LPN #1 stated that on 03/21/2026, the day after Resident #2 was discharged , she was instructed by a manager to go to the resident's home to remove the midline. LPN #1 further stated that she and Nursing Supervisor (NS) #1 went to the resident's house on 03/21/2026 to remove the resident's midline. An interview was conducted with Unit Manager (UM) #1 on 05/19/2026 at 12:34 PM. UM #1 stated that residents should not go home with IV access without a PO. UM #1 further stated that nurses should obtain a PO to remove the IV access when treatment is finished. UM #1 stated that Resident #2 was discharged home on [DATE]. UM #1 stated that a family member of Resident #2 called her and informed her that the resident was discharged home with IV access in place. UM #1 stated that it was not safe to send a resident home with IV access without a PO and the family was not educated on the device prior to discharge. An interview was conducted with NS #1 on 05/19/2026 at 1:37 PM. NS #1 stated that the process when a resident is discharged includes obtaining a PO for discharge, completing a full assessment, and educating the resident and family. NS #1 stated that a Registered Nurse (RN) or an LPN was responsible for removing IV access prior to discharging a resident. NS #1 stated that she was informed that Resident #2 was discharged without a head-to-toe check being completed and that the resident was discharged home with IV access in place. NS #1 stated that a body check is done prior to discharge to look for any devices or abnormal findings and document them. NS #1 stated that she went to Resident #2's home with another nurse to remove the resident's IV access after the resident had been discharged from the facility. An interview was conducted with the Director of Nursing (DON) on 05/19/2026 at 2:05 PM. The DON stated that Resident #2 did not have a PO to remove their midline at discharge, nor did the resident have a PO to keep their midline in place at discharge. The DON stated that there were no arrangements for care of the resident's IV access after discharge. The DON stated that Resident #2 should not have had the IV access in place when they were discharged from the facility. An interview was conducted with physician (PHY) #1 on 05/19/2026 at 4:13 PM. PHY #1 stated that residents are not normally discharged from the facility with IV access. PHY #1 stated that the usual process was for facility staff to contact him for an order to remove IV access. PHY #1 further stated that he was not aware that Resident #2 was discharged from the facility with a midline in place. The facility policy Physician Orders with an updated date of January 2025 was reviewed. Under Policy Statement, the facility (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy revealed that licensed nurses will obtain, document and provide care and services in accordance with orders received from the physician. Under Policy Interpretation and Implementation the facility policy revealed 4. Nursing staff will carry out the physician orders as directed by the physician. 5. The provision of care and services in accordance with the physician orders will be documented in accordance with professional standards of practice. The facility policy Peripheral IV Catheter Removal with a revision date of October 2024 was reviewed. Under General Guidelines the facility policy revealed 1. Evaluate the continued need for vascular access during provider visits and care planning. This section of the facility policy further revealed 2. Remove the peripheral/midline IV catheter if: a. vascular access is no longer clinically indicated. Under Documentation the facility policy revealed The following should be documented in the resident's medical record: 1. Date, time of procedure [.]. NJAC 8:39-27.1 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint: 3015011 Based on interviews, record review, and review of other pertinent facility documents it was determined that the facility failed to complete an incident report and thoroughly investigate after a resident was discharged from the facility with a midline catheter (long, flexible catheter inserted into larger veins of the upper arm) in place. This deficient practice was identified for 1 of 3 residents reviewed for the discharge process (Resident #2), and was evidenced by the following:Resident #2 was no longer at the facility. The closed medical record for Resident #2 was reviewed. A review of the admission record face sheet for Resident #2 revealed that the resident was admitted to the facility with diagnoses including but not limited to: pleural effusion (collection of fluid around the lungs), heart failure (heart muscle not pumping blood as well as it should), type 2 diabetes mellitus (body cannot use insulin correctly causing sugar build-up in the blood), malignant neoplasm of an unspecified site of unspecified female breast (abnormal growth of cells that are cancerous), and elevated white blood cell count (increased number of blood cells that help fight infection, aid in healing, and assist in recovery from disease). A review of the discharge Minimum Data Set (MDS) an assessment tool dated 03/20/2026, revealed that Resident #2 had a Brief Interview for Mental Status Score of 15 out of 15, which indicated that the resident's cognition was intact. A review of the Infectious Disease Nurse Practitioner Note with an effective date of 03/11/2026 at 10:49 AM, revealed a recommendation that Resident #2 start Vancomycin (antibiotic used to treat bacterial infections that are resistant to other antibiotics) 750 milligrams (MG) intravenously (IV) daily and ertapenem (antibiotic used to treat bacterial infections) 1 gram (GM) IV daily for 7 days for a sacral (triangular bone at the base of the spine) pressure ulcer which was covered with slough (dead tissue within a wound) and surrounded by cellulitis (infection of the skin and the soft tissues underneath). A review of the health status note with an effective date of 03/11/2026 at 2:30 PM, revealed that Resident #2 was to have a midline inserted by an outside company. The PN further revealed that the midline was for antibiotic therapy with vancomycin and ertapenem. Review of the Order Summary Report (OSR) for Resident #2 revealed the following physician orders (POs): Please place midline. The order date was 03/11/2026. Ertapenem sodium injection solution 1GM, IV one time for wound infection once medication arrives from the pharmacy. The order date was 03/11/2026. The start date was 03/12/2026. Ertapenem sodium Injection solution 1GM, IV every 24 hours for cellulitis for seven days. The order date was 03/11/2026. Vancomycin IV solution 750 MG per 150 ML one time a day for cellulitis. The order date was 03/11/2026. The start order date was 03/11/2026. A review of the Medication Administration Record (MAR) for Resident #2 revealed that the resident completed the prescribed dose of ertapenem on 03/17/2026. The MAR further revealed that Resident #2 completed the prescribed doses of vancomycin on 3/17/2026. A discharge note written by physician (PHY) #1, dated 03/20/2026 at 6:31 AM, was reviewed. The PN revealed that Resident #2's scheduled discharge date was 03/20/2026. The PN further revealed that the resident's prescriptions were written, and discharge instructions reviewed with the resident. Further review of the OSR revealed an order that Resident #2 could be discharged home on [DATE]. The order date was 03/20/2026. The order start date was 03/20/2026. The OSR did not reveal an order for the resident's midline to remain in place or an order to remove the midline. A late entry PN written by Licensed Practical Nurse (LPN) #1, dated 03/20/2026 at 2:27 PM, and entered into the facility electronic medical record on 03/21/2026 at 2:37 PM, was reviewed. The PN revealed that a midline catheter was removed from Resident #2's right upper extremity without complication and the site was assessed and found to be clean, dry, and intact. The PN further revealed that Resident #2 was prepared for discharge and left the facility at 2:45 PM, via medical transport and was accompanied by a family member. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 05/19/2026 at 4:27 PM. LPN #1 stated that she (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was the nurse who discharged Resident #2 from the facility on 03/20/2026. LPN #1 stated that she did not know that Resident #2 had a midline in place when they were discharged . LPN #1 stated that on 03/21/2026, the day after Resident #2 was discharged , she was instructed by a manager to go to the resident's home to remove the midline. LPN #1 further stated that she and Nursing Supervisor (NS) #1 went to the resident's house on 03/21/2026 to remove the resident's midline. An interview was conducted with Unit Manager (UM) #1 on 05/19/2026 at 12:34 PM. UM #1 stated that residents should not go home with IV access without a physician order (PO). UM #1 further stated that nurses should obtain a PO to remove the IV access when treatment is finished. UM #1 stated that Resident #2 was discharged home on [DATE]. UM #1 stated that a family member of Resident #2 called her and informed her that the resident was discharged home with IV access in place. UM #1 stated that she called the facility to follow up with NS #1, who was the NS on duty. UM #1 stated that she believed that facility staff went to the resident's home to remove the resident's IV access. UM #1 stated that it was not safe to send a resident home with IV access without a PO and the family was not educated on the device prior to discharge. UM #1 further stated that an incident report (IR) should have been completed if something was accidentally done and needed to be followed up on and rectified. UM #1 stated that she did not complete an IR related to Resident #2's discharge with IV access in place. An interview was conducted with NS #1 on 05/19/2026 at 1:37 PM. NS #1 stated that a Registered Nurse (RN) or an LPN was responsible for removing IV access prior to discharging a resident. NS #1 stated the day after Resident #2 was discharged , a family member called to inform NS #1 that the resident was discharged home with IV access in place. NS #1 stated that she requested that the family member take the resident to the emergency department to have the IV access removed but the family member declined. NS #1 stated that she was advised by facility management to go with another nurse to the resident's home to remove the IV access. NS #1 stated that she and another nurse went to Resident #2's home and removed the resident's IV access. NS #1 stated that this issue warranted an IR but she did not submit an IR and she was not sure if anyone had completed an IR. NS #1 further stated that the purpose of IRs was to follow up on incidents and to document actions that were taken to fix what happened. An interview was conducted with the Director of Nursing (DON) on 05/19/2026 at 2:05 PM. The DON stated that Resident #2 did not have a PO to remove their midline at discharge, nor did the resident have a PO to keep their midline in place at discharge. The DON stated that there were no arrangements for care of the resident's IV access after discharge. The DON stated that Resident #2 should not have had the IV access in place when they were discharged from the facility. The DON stated that if a resident was discharged with IV access in place without proper planning, it placed the resident at risk for bleeding, infection, or other negative repercussions. During the same interview the DON stated that she was not aware that Resident #2 was discharged with IV access in place, or that facility staff went to the resident's home to remove the IV access until the date of the survey (05/19/2026). The DON stated that she should have been called on 03/21/2026 when staff became aware of the issue. The DON stated that it was her expectation that an IR should have been completed related to Resident #2 being discharged with IV access in place. The DON stated that completion of an IR would have contributed to learning and preventing similar incidents from happening again. The facility policy Accidents and Incidents-Investigation and Reporting with a revision date of July 2017 was reviewed. Under Policy Statement the facility policy revealed that all accidents or incidents involving residents and employees occurring on the premises should be investigated and reported to the administrator. Under Policy Interpretation and Implementation the facility policy revealed 1. The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time accident or incident took place; b. The nature of the injury/illness [.] c. The circumstances surrounding the accident or incident; [.] g. The time the injured person's attending physician was notified, as well as the time the physician responded and his or her instructions; [.] 5. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident; [.] 7. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities. NJAC 8:39-27.1 (b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Complaint #:3015011 Based on interviews, record review, and review of pertinent documents, it was determined that the facility failed to ensure that the medical record accurately documented the care provided to a resident who was discharged home with a midline (long, flexible catheter inserted into larger veins of the upper arm) and had it removed in their home the next day by facility staff. This deficient practice occurred for 1 of 3 residents reviewed for discharge processes (Resident #2) and was evidenced by the following:Resident #2 was no longer in the facility. A closed record review was conducted. A review of the admission record face sheet for Resident #2 revealed that the resident was admitted to the facility with diagnoses including but not limited to: pleural effusion (collection of fluid around the lungs), heart failure (heart muscle not pumping blood as well as it should), type 2 diabetes mellitus (body cannot use insulin correctly causing sugar build-up in the blood), malignant neoplasm of an unspecified site of unspecified female breast (abnormal growth of cells that are cancerous), and elevated white blood cell count (increased number of blood cells that help fight infection, aid in healing, and assist in recovery from disease). Resident #2's discharge Minimum Data Set (MDS) an assessment tool dated 03/20/2026, was reviewed. The MDS revealed that Resident #2 had a Brief Interview for Mental Status Score of 15 out of 15, which indicated that the resident's cognition was intact. A late entry progress note (PN) written by Licensed Practical Nurse (LPN) #1 dated 03/20/2026 at 2:27 PM, and entered into the facility electronic medical record on 03/21/2026 at 2:37 PM, was reviewed. The PN revealed that a midline catheter was removed from Resident #2's right upper extremity without complication and the site assessed and found to be clean, dry, and intact. The PN further revealed that Resident #2 was prepared for discharge and left the facility at 2:45 PM, via medical transport and was accompanied by a family member. An interview was conducted with the Director of Nursing (DON) on 05/19/2026 at 2:05 PM. The DON stated that she became aware on the date of the survey (05/19/2026) that Resident #2 was discharged with a midline in their arm without a physician order to keep the midline in place; without having care arranged for the midline at the resident's home; and that facility staff went to the resident's home and removed the midline on 03/21/2026. During the same interview the late entry PN written by LPN #1, dated 03/20/2026 at 2:47 PM was reviewed with the DON. The DON confirmed that the PN did not reflect that the midline was removed from Resident #2's arm on 03/21/2026 at the resident's home. The DON stated that her expectation was for the PNs to reflect the care provided to the resident. The DON further stated that the PN dated 03/20/2026 at 2:47 PM was not truthful. An interview was conducted with LPN #1 on 05/19/2026 at 4:27 PM. LPN #1 stated that she did not know that Resident #2 had a midline when she discharged the resident. LPN #1 stated that Nursing Supervisor (NS) #1 informed her that the resident had been discharged with the midline and NS #1 and LPN #1 went to the resident's home to remove the midline on 03/21/2026. LPN #1 stated that she did not include in her PN that the midline was removed on 03/21/2026 at the resident's home. LPN #1 further stated that the PNs she writes should reflect what happened, and her PN dated 03/20/2026 does not reflect what happened with Resident #2. The facility policy Peripheral IV Catheter Removal with a revision date of October 2024 was reviewed. Under General Guidelines the facility policy revealed 1. Evaluate the continued need for vascular access during provider visits and care planning. This section of the facility policy further revealed that an IV catheter should be removed if vascular access is no longer clinically indicated. Under Documentation the facility policy revealed that the date and time of the IV device removal should be documented in the resident's medical record. The facility policy Charting and Documentation with a revision date of July 2017 was reviewed. Under Policy Statement the facility policy revealed that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's condition should be documented in the resident's medical record. This section of the facility policy further revealed that the medical record should facilitate (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication between the interdisciplinary team regarding the resident's condition and response to care. Under Policy Interpretation and Implementation the facility policy revealed, 2. The following information is to be documented in the resident medical record: [.] c. Treatments or services performed; [.] e. Events, incidents or accidents involving the resident; [.] 3. Documentation in the medical record will be objective [.], complete, and accurate; [.] 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided. NJAC 8:39- 35.2(d)16