

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Merry Heart Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Rt 10 West Succasunna, NJ 07876	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36419</p> <p>Complaint # NJ 00178498</p> <p>Based on observation, interviews, review of medical records, and facility documents, it was determined that the facility failed to follow fall prevention interventions as written on the resident's individual comprehensive care plan (ICCP). This deficient practice was identified for 1 of 3 residents (Resident # 14) reviewed for accidents and was evidenced by the following:</p> <p>On 1/10/25 at 11:09 AM, during the initial tour of the 1st-floor unit, the surveyor observed Resident #14 in a reclining chair in the day room with other residents and staff members.</p> <p>The surveyor reviewed the medical record for Resident # 14.</p> <p>A review of the Admission Record revealed the resident was admitted to the facility with diagnoses that included but were not limited to osteoporosis, Alzheimer's Disease, hypertension, and Chronic Obstructive Pulmonary Disease (COPD).</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/29/24, revealed Resident #14 had a Brief Interview for Mental Status of 1 out of 15, indicating the resident was severely cognitively impaired. Further review of the MDS revealed the resident was dependent on staff for Activities of Daily Living (ADL) care and bed-to-chair transfers.</p> <p>A review of Resident # 14's Individual Comprehensive Care Plan (ICCP) revealed a Focus: FALLS . The resident is at risk for falls due to deconditioning, gait, and balance problems On 6/10/24 had a witnessed fall . interventions included Ensuring two-person assistance during transfers. Bed kept in lowest position.</p> <p>A review of Resident #14's Plan of Care (POC), which was completed by their assigned Certified Nursing Assistant (CNA), indicated that Resident #14 required 2 staff and a Hoyer lift for the bed-to-chair transfers.</p> <p>A review of the facility-provided Fall Investigation revealed:</p> <p>(continued on next page)</p>

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:  315057	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Merry Heart Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  200 Rt 10 West Succasunna, NJ 07876	
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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/10/24 at 10:35 AM, the CNA did not follow Hoyer Lift transfers policy and procedure and transferred Resident #14 independently, without an assistant. The resident sustained three linear lacerations, one distal to the left eyebrow measuring .8x.1cm, below the left side of the eye measuring .2x.1cm, and below the second laceration measuring .2x.2cm with minimal bleeding. The MD was notified and ordered x-rays of the lumbar spine, left hip, and facial bones. All x-rays were negative for fractures.</p> <p>On 1/15/25 at 1:30 PM, the surveyor interviewed the DON and Assistant Licensed Nursing Home Administrator, who confirmed the facility's policy included that all Hoyer lift transfers required 2 staff members. The DON further stated that the CNA was terminated because the CNA did not follow the facility policy.</p> <p>The surveyor attempted a phone interview with the CNA who had transferred Resident #14 independently without the assistance of a second staff member. The CNA did not return the surveyor's call.</p> <p>On 1/16/25 at 8:55 AM, the surveyor interviewed Resident #14's assigned Licensed Practical Nurse (LPN), who stated that all Hoyer lift transfers required 2 staff assistants. The LPN further stated that the Director of Rehab educated all staff on safe transfers, which included the proper use of the Hoyer lift and two staff during those transfers.</p> <p>On 1/16/25 at 9:00 AM, the surveyor interviewed Resident #14's assigned CNA, who stated that she knew the resident well. She stated that she used a Hoyer lift when transferring the resident from the bed to the chair and always obtained the assistance of another CNA. The CNA further stated that she had received in-services on safe transfers, which included ensuring there were always 2 CNAs when using the Hoyer lift.</p> <p>On 1/16/25 at 9:10 AM, the surveyor interviewed the Director of Rehab (DOR), who stated that he was responsible for in-services for all staff on safe transfers. The DOR provided copies of the in-services completed prior to and after the fall.</p> <p>A review of the facility's Mechanical Lift policy and procedure, reviewed 6/2024, indicated . a mechanical lift allows a resident to be lifted and transferred with a minimum of physical effort. The Hoyer lift needs two caregivers to operate.</p> <p>A review of the facility's Fall Investigation policy and procedure implemented 7/2018, reviewed 7/2024 indicated .the objective of the Fall investigation was to analyze the cause of a fall and implement new initiatives to prevent future falls . The rehab director will screen and give recommendations .</p> <p>No further information was provided by the facility.</p> <p>NJAC 8:39-27.1 (a)</p>		