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	06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Merry Heart Nursing Home	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)
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 #2729626Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure a resident who was cognitively impaired and high risk for falls received adequate supervision to prevent accidents. This deficient practice was identified for 1 of 4 residents (Resident #122) reviewed for falls.On 6/24/26 at 9:15 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #122. The resident no longer resided at the facility.The admission Record (a summary of important information about a resident) documented that the resident had diagnoses that included but were not limited to, hydrocephalus (a medical condition where excess cerebrospinal fluid builds up within the brain's cavities), mild cognitive impairment of uncertain origin, restlessness and agitation, history of a transient ischemic attack (mini stroke), and difficulty walking.A comprehensive Minimum Data Set (MDS) assessment, a tool use to facilitate the management of care, with an assessment reference date of 12/24/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #122 scored 6 out of 15, which indicated the resident had severe cognitive impairment.Under Section GG (Functional Abilities) of the MDS assessment, Resident #122 was coded as needing substantial/maximal assistance for toileting hygiene. The resident was coded as needing partial/moderate assistance for showering/bathing self; upper body dressing, lower body dressing; putting on/taking off footwear; and personal hygiene (including combing hair, shaving, washing/drying face and hands). For mobility, Resident #122 was coded as needing substantial/maximal assistance for sitting to lying. The resident was coded as needing partial/moderate assistance with chair/bed to chair transfer; toilet transfer; tub/shower transfer; and walking 10 feet.A review of progress notes revealed the following:A nurse progress note dated 12/24/25 at 12:15 AM revealed at 11 PM (on 12/23/25) during rounds Resident #122 was found lying on the floor in their room. The resident did not know what happened. The resident sustained a laceration to left side of head and hematoma on left eyebrow. The staff called 911and at 11:20 PM the resident was transported to an emergency room (ER) for further evaluation. A follow-up progress note dated 12/24/25 at 1:40 AM indicated a call from the ER nurse was received, a computed tomography (CT) scan (an imaging test) was done with negative results, and the resident would be returning to the facility. The resident's representative (RR), the primary physician, and the Director of Nursing (DON) were made aware of the incident.A nurse's progress note dated 1/1/26 at 6:45 PM revealed at 5 PM the nurse was notified Resident #122 had an unwitnessed fall incident in the bathroom; the resident was sitting on the floor. Resident #122 stated they were trying to clean themself up and were not hurt. RR #2, and a nurse practitioner (NP) were made aware of the incident.A nurse's progress note dated 1/6/26 at 11:21 AM revealed at 10:30 AM another nurse notified the assigned nurse that Resident #122 had an unwitnessed fall inside room [ROOM NUMBER]'s bathroom and was found sitting on the floor. room [ROOM NUMBER] was two doors down and across from Resident #122's room. The resident was assessed with no apparent injuries, the call bell was not activated, and their pants were soiled. The RR and a NP were made aware of the incident.A nurse's progress note dated 1/8/26 at 11:11 AM revealed at 10:15 AM the nurse was (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed by a Certified Nurse Aide (CNA) that Resident #122 had an unwitnessed fall inside their room. The resident stated they were trying to get up. The resident was assessed with no apparent injuries, call bell not activated, they were not soiled and wore socks. The RR and a NP were made aware of the incident.A nurse progress note dated 1/24/26 at 4:33 PM revealed at 3:45 PM the CNA notified the nurse that Resident #122 had an unwitnessed fall inside 224 bathroom and was found lying on the floor. The resident stated they were going to the bathroom and were not hurt. The resident was assessed with no apparent injuries, the call bell was not activated, and the resident was not soiled. The RR and a NP were made aware of the incident.A nurse's progress note dated 1/26/26 at 11:25 PM revealed at 7:38 PM in a hallway Resident #122 was sitting on the floor and grabbing the handrails. The resident was assessed with no apparent injuries, and the resident was not soiled. Resident #122 was assisted back to their wheelchair with two-person assist. The primary physician, the DON and the RR were made aware of the incident. A nurse progress note dated 1/27/26 at 1:23 PM revealed Resident #122 was discharged via wheelchair in stable condition for a routine home discharge. On 6/24/26 at 10:40 AM, the surveyor requested from the DON fall investigations for Resident #122.On 6/24/26 at 9:30 AM, the DON provided the surveyor with the fall investigations for Resident #122. The investigations included a summary, evaluation of potential contributing factors, staff statements as needed, and conclusion of the investigation. The investigations revealed the following:For the 12/23/25 fall at 11 PM, the intervention to prevent future falls was to check Resident #122 around 10:30- 11 PM for safety and care needs. Staff were provided with education on new care plan intervention.For the 1/1/26 fall at 5 PM, an aide was in the bathroom assisting the resident. The resident's pants were soiled, and the aide left the resident in the bathroom to retrieve a clean pair of pants. Upon their return, the resident was found sitting on the floor. The intervention to prevent future falls was to ensure that the resident was not left unattended in the bathroom. Staff were provided with education on new care plan intervention.For the 1/6/26 fall at 10:30 AM, an empty chair was observed outside of room [ROOM NUMBER] by a nurse. Upon looking in the room, Resident #122 was found sitting on the bathroom floor. The intervention to prevent future falls was to check Resident #122 for safety and needs, including offering toileting between 10 to 10:30 AM. Staff were provided with education on new care plan intervention.For the 1/8/26 fall at 10:15 AM, during rounds the resident was found lying on the floor in their room. The intervention to prevent future falls was upon waking up, Resident #122 would be assisted with getting ready for the day and closely monitored outside their room, by the nurses' station. Staff were provided with education on new care plan intervention.For the 1/24/26 fall at 3:45 PM, it was revealed that the resident was found lying on the floor in their bathroom. The intervention to prevent future falls was to remind visitors to notify staff once they were leaving to closely monitor Resident #122. Staff were provided with education on new care plan intervention.For the 1/26/26 fall at 7:38 PM, indicated the resident was assisted with toileting one hour prior to the fall and last seen by staff at 7:30 PM sitting in their wheelchair in the hallway. The planned intervention to prevent future falls was to ensure Resident #122 was in front of the nursing station for closer supervision. Staff were provided with education on new care plan intervention.On 6/24/26 at 10:55 AM, the surveyor interviewed a Registered Nurse (RN) who cared for Resident #122. Fall prevention interventions for high fall risk residents included a low bed position, making sure personal items were within reach, and frequent monitoring of a resident which may include putting them closer to the nurses' station. The RN also explained care plans were reviewed and updated with resident centered interventions after a fall to prevent further incidents. The RN recalled Resident #122 who she stated was very confused at times, and a very high risk for falls due to having multiple falls. The RN stated Resident #122 used a wheelchair and was able to propel themself. The RN further explained that the resident was able to feed self with set up but required assistance by staff with other activities of daily living (ADLs). The RN could not recall details of the resident fall incidents or specific interventions.The surveyor asked about assisting cognitively impaired and high fall risk residents in the bathroom. The RN stated that residents should be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored and not left unattended. The RN added residents who required closer supervision would be placed by the nurses' station as there would be more staff to monitor them. Recreational activities, depending on a resident's preferences, would be provided.On 6/25/26 at 11:20 AM, the surveyor informed the DON, the Licensed Nursing Home Administrator (LNHA), and the Assistant Administrator (AA) about the concern of the provision of appropriate supervision to prevent falls for Resident #122 and the resident continuing to have multiple falls despite interventions implemented.On 6/26/26 at 11:14 AM, the DON stated that Resident #122 moved quickly and was impulsive. The DON explained that the resident was care planned after each fall and staff did their best to try to prevent falls. The DON stated for the 1/1/26 fall in which the resident was left in the bathroom for the aide to retrieve another pant, in-service education was provided to the staff. The DON stated for the concern with the 1/6/26 fall in which Resident #122 was found in another room, that the room was across from the resident's room and the resident entered the room in error. The surveyor discussed that a tour of the floor was done and the room the resident was found was two doors down and across from their assigned room as well as further away from the nurses' station. Additionally, the resident's empty wheelchair was found by the door, the resident made their way inside of the room and was found on the bathroom floor of the room. There was no additional response provided by the facility.A review of the facility's Preventing Falls policy, last reviewed on 1/28/26, revealed an objective To be able to reduce incidence of falls and injuries resulting from falls. Under Procedures revealed, 9. Residents will be observed closely, kept occupied with activities and needs will be anticipated to prevent falls (e.g., in front of nursing station, toileting, kept occupied with activities, ambulated, etc).NJAC 8:39-27.1(a)