STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315487	A. Building B. Wing	08/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Preferred Care at Mercer	1201 Parkway Avenue Ewing, NJ 08628

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #:2575153 Based on observation, interviews, medical record review, and review of pertinent facility documents, it was determined that the facility failed to administer medications with less than a 5% medication error rate. The surveyor observed one nurse administer medications to four residents with a total of 43 opportunities. Three errors were observed, which calculated to a medication administration error rate of 6.97%. This deficient practice was identified for two of four residents that were administered medications by 1 nurse on the first-floor sub-acute nursing unit.This deficient practice was evidenced by the following: 1.) On 08/01/2025 at 8:45 A.M., the surveyor observed the Registered Nurse (RN #1) preparing and administering medications for an unsampled resident. RN #1 removed a jar labeled as vitamin C 500 milligram (MG) tablets from the medication cart and poured one tablet into the medication cup with the other medications being prepared for the resident. RN #1 continued to prepare the resident's medication. At that time the surveyor observed the physician's order (PO) for vitamin C which indicated to administer one 250 MG tablet, not a 500 MG. The surveyor stopped RN #1 to confirm that she was finished preparing medication for the resident and was prepared to administer them. RN #1 reviewed the vitamin C order and stated, I didn't notice that. The RN obtained 250 MG tablets for administration to the resident. (error #1) During the same medication preparation and administration observation, the surveyor observed RN #1 place two carbamazepine (a medication used to treat seizures, nerve pain, and mental health disorders) chewable 100 MG tablets into the medication cup with other medications being prepared for the unsampled resident. The chewable tablets were administered to the resident with their other medications and swallowed by the resident without being chewed. RN #1 confirmed that the carbamazepine 100 MG tablets were swallowed along with the resident's other medications without being chewed. (error #2) A review of the unsampled resident's admission Record (AR) revealed that the resident was admitted with diagnoses including but not limited to epilepsy (brain condition that causes recurring seizures), unspecified, intractable, without status epilepticus; chronic kidney disease, unspecified; bipolar disorder (disorder that causes intense shifts in mood, energy levels and behavior), unspecified; and type 2 diabetes mellitus with unspecified complications. The most recent Minimum Data Set (MDS), an assessment tool dated 06/25/2025, was reviewed. The MDS revealed that the resident had a brief interview for mental status (BIMS) score of 12 out of 15, indicating that the resident's cognition was moderately impaired. A review of the resident's physician orders POs revealed the following orders: Ascorbic acid (commonly known as vitamin C) tablet 250 MG; give 1 tablet by mouth two times a day for supplement. carbamazepine tablet chewable 100 MG; give 2 tablets by mouth two times a day for seizures related to epilepsy, unspecified, intractable, without status epilepticus 2.) On 08/01/2025 at 10:00 A.M., the surveyor observed RN #1 prepare Resident #1's medications for administration. The surveyor observed RN #1 pour 30 milliliters (ML) of lactulose (a laxative medication also used to treat complications of liver disease) 10 grams (GM)/15 milliliter (ML) solution for administration to Resident #1. At that time the surveyor observed the PO for lactulose which indicated to administer 15 ML, not 30 ML. The surveyor stopped the RN #1 and confirmed that she was finished preparing medication for the resident and was prepared to administer them. RN #1 reviewed the lactulose order and confirmed that 15 ML was ordered. RN #1 poured 15 ML of Lactulose and administered it to Resident #1 with the resident's other medications. (error #3) A review of the Resident #1's AR revealed that the resident was admitted with diagnoses including but not limited to acute and subacute infective endocarditis (infection of the heart lining or valves); unspecified cirrhosis of the liver (healthy liver cells replaced by scar tissue); presence of cardiac pacemaker; hypo-osmolality (decrease in levels of electrolytes, chemicals, and other fluids in the blood) and hyponatremia (low sodium level in the blood); and irritable bowel syndrome (a chronic condition that causes abdominal pain and trouble with bowel habits). Resident #1's most recent MDS dated [DATE], was reviewed. The MDS revealed that the resident had a BIMS score of 15 out of 15, indicating that the resident's cognition was intact. The MDS further revealed that the resident was frequently incontinent of stool and was dependent on a helper for toilet transfers and toileting hygiene. A review of Resident #1's POs revealed the following order: Lactulose oral solution 10 GM/15 ML; give 15 ml by mouth three times a day for cirrhosis. An interview was conducted with RN #1 on 08/01/2025 at 1:40 P.M. RN #1 confirmed that she was prepared to administer 500 MG ascorbic acid to the unsampled resident and 30 ML of lactulose to Resident #1. RN #1 stated that she was unsure if the unsampled resident's carbamazepine should have been chewed. RN #1

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint #: 2575153 Based on interviews, record review, and review of other pertinent facility documents on 08/01/2025, it was determined that the facility failed to ensure that a resident (Resident #2) received the correct intravenous (IV) antibiotic medication. This deficient practice was identified for one of three residents reviewed for medication errors and was evidenced by the following: According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses including but not limited to peritoneal abscess (pocket of pus and infected fluid in the tissue lining the abdomen); sepsis (life-threatening condition caused by the body's response to an infection), unspecified organism; bacteremia (bacteria in the blood); pneumonia (inflammation and fluid in the lungs), unspecified organism; and other specified anxiety disorders (conditions that cause fear, dread and other symptoms out of proportion to the situation). According to the most recent Minimum Data Set (MDS), an assessment tool dated 07/28/2025, Resident #2 had a Brief Interview of Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. A review of the facility incident report dated 07/26/2025 at 6:26 P.M., was conducted. Under, Incident Description, the document revealed the following: Nursing Description: [Resident #2] received IV Ceftin [an antibiotic] instead of the ordered Daptomycin [an antibiotic]. Resident admitted to this facility on 07/23/205 after a brief stay at [hospital name] to complete IV [antibiotic] therapy for blood infection/MRSA [methicillin-resistant Staphylococcus aureus, a bacterium that is resistant to antibiotics] bacteremia. A facility Witness Statement, document from RN #2 with the date July 27 with a six written over the 7 was reviewed. The statement revealed that at 6:00 P.M., RN #2 brought two bags of IV medication into Resident #2's room, one belonged to Resident #2 and the other belonged to a different resident. RN #2 began the administration of Ceftin which belonged to another resident instead of the Daptomycin, which was the IV antibiotic prescribed to Resident #2. The statement further revealed that RN #2 noticed the error and stopped the Ceftin infusion in less than three minutes. The physician was notified, and the resident was monitored for signs of complication. Resident #2 was no longer at the facility. A closed record review was conducted. A review of the Order Summary Report (OSR), for Resident #2 revealed the following physician order (PO): Daptomycin-Sodium Chloride Intravenous Solution 700-0.9 MG [milligrams]/100 ML [milliliters]- %(Daptomycin-Sodium Chloride) Use 100 ml intravenously one time a day for Cholecrtectomy until 07/27/2025 23:59 [11:59 P.M.]. The order had a start date of 07/24/2025 and an end date of 07/27/2025. A further review of the OSR revealed no POs for Ceftin for Resident #2. A telephone interview was conducted with RN #2 on 08/01/2025 at 12:53 P.M. RN #2 stated that the medication administration process included verification of the resident's name, medication dose, medication route, and documentation. RN #2 stated that on 07/26/2025 he gave the wrong IV medication to Resident #2. RN #2 stated that he brought two medications into Resident #2's room (one for Resident #2, and one for a resident in another room). RN #2 stated that he administered Ceftin instead of daptomycin to Resident #2. RN #2 stated that prior to administering the medication, he verified Resident #2's identity but not the medication he was giving. RN #2 stated that he noticed the error as soon as he left the resident's room, which was in less than one minute. RN #2 further stated that following the rights of medication administration was important for preventing errors and that medication errors could cause allergy, itching, or diarrhea depending on the medication. An interview was conducted with the Unit Manager (UM #1) on 08/01/2025 at 3:02 P.M. UM #1 stated that the expectation was that medications were given following the rights of medication administration, facility policies, and physician orders. UM #1 further stated that if medications were not administered according to facility policies and her expectations, harm could be caused to a resident and, that's the last thing we want. An interview was conducted with Director of Nursing (DON) on 08/01/2025 at 3:46 P.M. The DON stated that the expectation every time medication was administered was that it was done according to the facility medication administration policy and the five rights of medication administration. The DON stated that when the wrong antibiotic was administered to Resident #2, the five rights of medication administration were not followed. The DON further stated that if medications were not administered according to the facility policy and the five rights of medication administration, the consequences to the resident could range from sneezing to death. A review of the facility's, Medication Administration policy with a reviewed date of 1/2025 revealed under, Policy Explanation and Compliance Guidelines; .10. Review EMAR to identify medication to be administered. 11. Compare medication source (bubble pack, vial, etc.) with EMAR [electronic medication administration record] to verify resident name, medication name, form, dose, route, and time [.] 14. Administer medication as ordered in accordance with

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2575153Based on observation, interviews, record review, and review of other pertinent facility documents it was determined that the facility failed to maintain appropriate infection control practices during medication administration in accordance with in nationally accepted guidelines for infection prevention and control and the facility's policies and procedures. This deficient practice was identified for 2 of 2 residents (Resident #1 and Resident #2) reviewed for infection prevention and was evidenced by the following:1. A facility incident report dated 07/26/2025 at 6:26 P.M., was reviewed. Under, Incident Description, the document revealed the following: Nursing Description: [Resident #2] received IV Ceftin [an antibiotic] instead of the ordered Daptomycin [an antibiotic]. [Resident #2] admitted to this facility on 07/23/205 after a brief stay at [hospital name] to complete IV [antibiotic] therapy for blood infection/MRSA [methicillin-resistant Staphylococcus aureus, a bacterium that is resistant to antibiotics] bacteremia. A facility Witness Statement, document written by the Registered Nurse (RN #2) with the date July 27 with a six written over the seven was reviewed. The statement revealed that at 6:00 P.M., RN #2 brought two bags of IV medication into Resident #2's room, one belonged to Resident #2 and the other belonged to a different resident. RN #2 then administered another resident's IV antibiotic to Resident #2. Resident #2 was no longer at the facility. A closed record review was conducted. According to the admission Record (AR), Resident #2 was admitted to the facility with diagnoses included but were not limited to: peritoneal abscess (pocket of pus and infected fluid in the tissue lining the abdomen); sepsis (life-threatening condition caused by the body's response to an infection), unspecified organism; bacteremia (bacteria in the blood); pneumonia (inflammation and fluid in the lungs), unspecified organism; and other specified anxiety disorders (conditions that cause fear, dread and other symptoms out of proportion to the situation). According to the most recent Minimum Data Set (MDS), an assessment tool dated 07/28/2025, Resident #2 had a Brief Interview of Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. A review of the Order Summary Report (OSR), for Resident #2 revealed the following physician orders (POs): Maintain contact isolation precautions due to MRSA; every shift for isolation precautions. The order start date was 07/23/2025. Midline single lumen (vascular access device used for infusion therapies) RUA (right upper arm) measurement 4.5 Fr (French) 15 CM (centimeters) long. The order start date was 07/23/2025. Daptomycin-sodium chloride intravenous solution 700-0.9 MG [milligrams]/100 ML [milliliters]. Use 100 ml intravenously one time a day until 07/27/2025 11:59 P.M. The order had a start date of 07/24/2025 and an end date of 07/27/2025. A review of the Care Plan (CP) for Resident #2 revealed a Focus, that the resident required enhanced barrier precautions (EBPs) related to a wound, a midline catheter, and MRSA. Interventions included but were not limited to: clear signage posted on or near the room door; good hand hygiene when entering or leaving the room; and maintaining EBP for the duration of the stay, until wound healing, or removal of the indwelling device. The CP for Resident #2 also included a Focus, that the resident had MRSA bacteremia. Interventions included but were not limited to: observation of standard precautions (minimum set of interventions considered standards of care that prevent the transmission of microorganisms); thorough cleaning of resident areas using disinfectants; and cleaning, disinfecting or sterilizing resident care equipment. A telephone interview was conducted with RN #2 on 08/01/2025 at 12:53 P.M. RN#2 stated that on 07/26/2025 he brought two bags containing intravenous (IV) medications into Resident #2's room (one for Resident #2, and one for a resident in another room). RN #2 stated that he then administered Ceftin instead of Daptomycin to Resident #2. 2.) A medication administration observation was conducted on 08/01/2025 at 10:13 A.M. The surveyor observed RN #1 during the administration of IV antibiotics to Resident #1. After exiting the room RN #1 returned wearing gloves that she touched the door and door handle with. RN #1 wearing the same gloves that she touched the door handle with then removed an empty IV medication bag from the IV pole and hung the new medication. RN #1 then set the IV pump and connected the new tubing to Resident #1's IV line while wearing the same gloves. A review of Resident #1's AR revealed that the resident was admitted with diagnoses that included but were not limited to acute and subacute infective endocarditis (infection of the heart lining or valves), and presence of cardiac pacemaker. Resident #1's most recent MDS dated [DATE], was reviewed. The MDS revealed that the resident had a BIMS score of 15 out of 15, indicating that the resident's cognition was intact. The MDS further revealed that the resident had central IV access on admission to the facility. A review of Resident #1's OSR revealed the following PO: Maintain