

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/03/2025
NAME OF PROVIDER OR SUPPLIER  Preferred Care at Mercer		STREET ADDRESS, CITY, STATE, ZIP CODE  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 0686  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing.  (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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide necessary treatment and services as ordered by the physician to promote the healing of a wound. The deficient practice was identified for 3 of 3 residents (Resident #1, #2, and #3) reviewed for wound care. The deficient practice was evidenced by the following: A review of Resident #1 admission Record revealed medical diagnosis which included but not limited to dementia and chronic kidney disease. Review of the most recent quarterly Minimum Data Set (MDS), an assessment tool revealed the resident had a Brief Interview of Mental Status (BIMS) of 12, meaning the resident had moderate cognitive impairment. A review of the physician orders showed the following order: Medihoney (wound/burn dressing gel) to right posterior hip topically every eight hours for wound healing. Cleanse with normal saline, apply Medihoney and calcium alginate (absorbs wound drainage) and cover with a foam dressing. The order was dated 10/29/25 and was an active order. A review of the Treatment Administration Record (TAR) showed the Medihoney order to be administered on day shift (7AM to 3PM), evening shift (3PM to 11 PM), and night shift (11PM to 7 AM). The TAR was signed as the treatment was completed, the last treatment being 11/3/25 on day shift. Review of Resident #1 Individualized Comprehensive Care Plan (ICCP) initiated 11/30/24 showed a focus of actual skin impairment related to bowel and bladder incontinence and impaired mobility. Interventions included but were not limited to administering treatment as ordered. On 11/3/25 at 10:40 AM, during unit tour with the Unit Manager (UM) the surveyor observed the dressing on Resident #1 right posterior hip. The dressing had a date of 11/2/25 with the words day shift written on the dressing. The surveyor then interviewed the UM regarding the dressing. The UM confirmed the dressing was dated 11/2/25 and said day shift. The surveyor asked why the TAR was signed as the dressing being changed three times after the 11/2/25 day shift dressing and she stated, Maybe there was a reason it wasn't done. A review of the admission Summary for Resident #2 revealed the resident was admitted to the facility with medical diagnoses which included but were not limited to diabetes and diabetic foot ulcer. A review of the admission MDS showed Resident #2 had a BIMS of 12, meaning the resident had moderate cognitive impairment. A review of the physician orders showed an order to apply Xeroform (gauze nonstick dressing to promote wound healing), then apply gauze pad, and wrap with Kling (gauze bandage) to left heel/graft daily every evening for wound care. The order was placed on 7/5/25 and then discontinued 7/7/25. On 7/10/25 the order was changed to calcium alginate to left heel topically after cleaning with normal saline solution and applying Santyl (ointment that removes dead tissue) ointment. A review of the ICCP for Resident #2, initiated on 7/4/25 showed a focus of impaired skin integrity with interventions which included but not limited to administer treatment as ordered. A review of the TAR showed that on 7/6/25 and 7/10/25 the TAR was blank, meaning the wound care was not provided. A review of the admission Summary for Resident #3 revealed medical diagnoses which included but were not limited to Multiple Sclerosis (progressive neurological disease), muscle weakness, and hypertension. A review of the most recent quarterly MDS revealed Resident #3 had a BIMS of 9, meaning the resident had moderate cognitive impairment. A review of the physician orders showed the following orders related to wound care: Calcium alginate, cleanse with normal saline solution apply calcium alginate and cover with foam dressing every day shift and every evening shift to right ischial wound. A review of the TAR showed the wound care was completed on 11/1/25 day and evening shift, 11/2/25 day and evening shift, and 11/3/25 day shift. On 11/3/25 at 10:45 AM, with the UM the surveyor observed the residents right ischial dressing. The dressing was dated 11/2/25 day shift. The surveyor asked the UM if the dressing would be dated 11/2/25 if it was completed on 11/2/25 evening shift and 11/3/25 day shift and the UM responded, No, it wasn't done. A review of Resident #3 ICCP initiated 4/22/25 showed a focus of actual skin integrity. Interventions included but were not limited to administer treatment as ordered. On 11/3/25 at 1:40 PM, the surveyor interviewed the Director of Nursing regarding wound care. The surveyor asked if the TAR is signed by the nurse what would that mean, and she responded that it should be done. The DON then presented the surveyor with progress notes of resident refusal that were created after the surveyor inquiry. The surveyor reviewed the policy titled, Pressure Ulcer/Wound Treatment Management, with a review date of 2/1/25. The policy was to promote wound healing of various types of wounds, it is the policy of the facility to provide evidence-based treatments in accordance with the current standards of practice and physician orders. Number one of the policy was that wound treatments would be provided in accordance with physician orders. N.J.A.C. 8:30-27.1(a)</p>		