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	01/15/2026

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

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and facility policy review the facility failed to implement pharmacy processes for labeling medications, including controlled substances (CS), for four of four medication carts (Medication Carts One and Two on [NAME] Unit; Medication Carts One and Two on Ewing Unit) observed for medication storage and labeling of 27 sample residents. This failure had the potential risk of drug diversion, theft, improper handling of returns, all impacting patient safety and compliance.Findings include:During observation of medication cart one on the [NAME] Hall on 01/13/26 at 1:00 PM, Licensed Practical Nurse (LPN) 2 revealed routine and controlled medications blister pack labels and controlled substance inventory log sheets located in medication cart one, which reflected See MD [Medical Doctor] orders as medication administration directions for use in accordance with the physician's orders.During an interview on 01/13/26 at 1:15 PM, LPN2 said that the nurses who received the medications including controlled substances, from the pharmacy, were responsible for ensuring the resident's name, prescribing doctor, directions for medication administration, the Rx (prescription) number, the name of the issuing pharmacy, and the Rx issue date reflected on the medication blister pack(s) label and on the narcotic inventory sheet. LPN2 said that the pharmacist consultant also checked the medication labels and narcotic inventory sheets when on-site to conduct a medication cart audit. LPN2 said that See MD orders was not an actual direction for use, but a reference to the resident's medication administration record (MAR) for specific instructions.During observation of medication cart two on [NAME] Hall on 01/13/26 at 3:45 PM, Registered Nurse (RN) 2 revealed routine and controlled medications blister pack labels and controlled substance inventory log sheets located in medication cart two, which reflected See MD Orders as medication administration directions for use in accordance with the physician's orders.During an interview on 01/13/26 at 3:59 PM, RN2 said he/she reviewed the MAR for instructions to administer medications to the resident. RN2 said that See MD Orders printed as the instructions for use did not follow the medication rights for verification to check the medication label against the order in the MAR before giving to the resident. RN2 stated not verifying the medication label against the physician's order could potentially risk patient safety. RN2 said that controlled substances could be miscounted or incidents of drug diversion when the medication blister pack did not reflect the number of pills that should be administered.During random observations of medication cart one on 01/14/26 at 8:30 AM with LPN1 and medication cart two at 8:40 AM with the Long-term Unit Manager (LTUM) on the Ewing Hall revealed routine and controlled medications blister pack labels and controlled substance inventory log sheets, reflected See MD Orders as medication administration directions for use in accordance with the physician's orders.During an interview on 01/14/26 at 10:04 AM, the Sub-Acute Unit Manager ([NAME]) stated that See MD Orders, was a process throughout the facility to prevent the need for clarification or to question orders with the physician. He/she said that the physician's wrote orders in the hard chart and any clarification of orders would be done before entered into the electronic medical record (EMR). The [NAME] said that he/she checked the EMR after a new admit ensuring orders were entered correctly and matched the discharge orders. The (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[NAME] said that he/she periodically checked physician orders in the EMR that they were entered correctly.During a phone interview on 01/15/26 at 9:45 AM, the Certified Pharmacy Consultant (CPHC) said that he/she conducted medication cart audits at the facility to systematically check for regulatory compliance including proper labeling that aligned with the MARs/orders, which was essential for patient safety. The CPHC said that audits confirmed adherence to policies, identified system failures, provided education, and prevented errors with high-risk meds. The CPHC said that pharmacies in the State of New Jersey were not required to write out the instructions for use on the label of the drug card and that See MD Orders was appropriate.During an interview on 01/15/26 at 12:16 PM, the Director of Nursing (DON) said that the nurses and Unit Manager were responsible for overseeing procedures that prevented medication errors and drug diversion such as performing the medication rights, ensuring the medication label and MAR matched, in that it was the right medication, right dose, right form, given at the right time, to the right resident via the right route. The DON said that the pharmacy consultant also audited the medication carts every two to three months to ensure that the facility complied with policies and procedures. The DON said that the label instructed the nurse to See MD Orders and the MAR would indicate how to administer the medication.Review of the facility's policy titled, LTC [Long Term Care] Pharmacy Services, revised 06/19/23, provided by the DON, indicated, PURPOSE To ensure that all medications are properly labeled. POLICY All medications dispensed or stored in the pharmacy must be labeled as per procedure. PROCEDURE Medications dispensed to residents are appropriately and safely labeled. Any labeling that is consistent with law, regulation and professional practice Intravenous (IV) medication labels shall have labels that bear: The Resident's full name; The prescriber's name; The prescription number; The name and strength of drug; The quantity dispensed; The lot number; The date of Issue; The expiration date; The manufacturer's name if generic; Cautionary and/or accessory labels; Directions for use . NJAC 8:39-5.1(a)NJAC 8:39-29.1NJAC 8:39-29.4

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policy review, the facility failed to prevent the build-up of grease, food crumbs, and dirt on fixed equipment, behind cooking equipment and on walls and floors for one of one kitchen, as well as failing to clean and maintain two of three ice machines in the facility. This deficient practice had the potential to affect 84 of 84 residents who received meals and beverages prepared in and served from the facility's kitchen and pantries. Findings include:1.During the initial kitchen tour and observation on 01/12/26 at 9:58 AM, the dishwasher revealed the tile wall and floor behind and underneath the dishwasher, covered in dark blackish-brown debris consisting of grease, food debris and dust and dirt. The debris was observed covering the surface and undercarriage of the heating unit. The observation also revealed the dark blackish-brown debris on the legs of the steam table, food preparation tables and shelves, and build-up of grease and residue on the outside of the gas range and the double ovens.During an interview on 01/12/26 at 10:03 AM, the Dietary Manager (DM) was asked about the soiled surfaces behind and under the dishwasher and peripheral equipment, and he/she advised that they tried to clean them daily. During observations on 01/14/26 at 10:51 AM and on 01/15/26 at 8:35 AM, the range, double ovens, steam table, and preparation surface areas behind and beneath the equipment remained soiled. During an interview on 01/15/26 at 8:35 AM, the DM was asked about the areas, and he/she stated that they tried to remove the debris with a pressure washer but had not been successful. He/she did, however, reveal that the area behind and underneath the dishwasher had been thoroughly cleaned and was free of debris. 2. During an observation on 1/14/26 at 10:30 AM, the 100 Unit ice machine revealed a slimy, brownish colored substance on the inside and outside of the chute. Located on the machine was a document titled, Ice Machine Inspection - Quarterly. The document also included the location of the inspection/log, Long term unit, for the year 2025. Per the log, the coils and motor were cleaned, and the filter was checked and replaced, but not dated. The log was signed off by the Maintenance Director (MD) for each quarter. An observation of the ice machine on the sub-acute unit, on 01/15/25 at 8:35 AM, revealed the same brownish colored substance on the chute, along with slimy blackish-brown and white bio-growth on the metal areas of the chute assembly. The unit also included a log that revealed the coils and motor were cleaned, dated 12/13/25, and the filter was checked and replaced quarterly.During an interview on 01/15/25 at 9:10 AM, the Housekeeper (HK) 1 was asked who was responsible for the ice machines and he/she advised that maintenance was responsible for maintaining the ice machine. During an interview on 01/15/26 at 11:28 AM, the MD stated that the maintenance department was responsible for wiping down the machine daily, the ice machine regularly, which included taking the machine apart every 90 days to clean the internal parts. Review of the U.S. Food and Drug Administration's (FDA) 2022 Food Code, dated 01/08/25 and located at https://www.fda.gov/food/fda-food-code/food-code-2022, page 114, revealed ice makers should be cleaned, (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold.Review of the facility's policy titled, General Kitchen Sanitation, dated June 2019, revealed The Facility recognizes that food-borne illness has the potential to harm patients/residents. All Dietary employees will maintain clean, sanitary kitchen facilities in accordance with the county health department regulations and the current Federal and State Food Codes in order to minimize the risk of infection and food borne illness. Step one of policy procedure revealed to Clean and sanitize all food preparation areas, food-contact surfaces, dining facilities and equipment. After each use, clean and sanitize all tableware, kitchenware and food contact surfaces and equipment. NJAC 8:39-17.2(g)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure Notice of Medicare Non-Coverage (NOMNOC) notification was provided timely for two of three residents (Resident 5 and R32) reviewed for beneficiary notification of 27 sample residents. This had the potential to affect all residents being discharged from services. Findings include:1. Review of R5's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including Alzheimer's. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/01/26 and located in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of five out of 15, which indicated the resident's cognition was severely impaired.Review of R5's SNF [Skilled Nursing Facility] Beneficiary Notification Review form revealed Medicare Part A skilled services start date was 08/23/25 and the last day covered was 10/15/25. Further review revealed Advance Beneficiary Notice of Noncoverage (ABN) notification was dated 10/10/25 and had initials written on the signature line.Review of R5's Nurse's Note located in the Notes tab of the (EMR) and dated October 2025 and November 2025 revealed no documentation related to a discussion with R5 about notice of Medicare noncoverage. During an interview on 01/15/25 at 3:40 PM with R5's Responsible Party (RP) who stated he/she was never contacted about R5's right to appeal his/her therapy benefits ending. The RP stated he/she was never asked, and he/she did not give permission for R5 to sign the beneficiary form in his/her place. He/she said R5 would not have been able to understand what he/she was signing. The RP stated he/she would have liked to have been made aware about the right to appeal because he/she certainly would have thought about if he/she should have appealed had he/she been made aware. 2. Review of R32's admission Record located in the Profile tab of the electronic medical record (EMR) revealed she was admitted to the facility on [DATE] with diagnoses including muscle wasting and atrophy.Review of R32's quarterly MDS with an ARD of 11/30/25 and located in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident's cognition was severely impaired. Review of R32's SNF Beneficiary Notification Review form revealed Medicare Part A skilled services start date was 09/23/25 and the last day covered was 11/04/24. Further review revealed ABN was dated 10/31/25 and it stated refused to sign. Review of R32s Nurse's Note located in the Notes tab of the (EMR) and dated October 2025 and November 2025 revealed no documentation related to a discussion with R32's responsible party (RP) about notice of R32's Medicare noncoverage. Further review revealed no note related to a discussion with R32 or her refusal to sign the form. During an interview on 01/15/25 at 12:15 PM, R32 was shown the NOMNOC and stated he/she was unable to read due to his/her cataracts. R32 stated he/she was not informed that he/she had a right to appeal. He/she said that was never said to him/her. R32 said he/she had no memory of refusing to sign the NOMNOC form.During an interview on 01/15/26 at 1:43 PM, the Social Services Director (SSD) said when a resident needed to be notified of noncoverage of Medicare he/she spoke with the family, and the residents and made them aware their benefits would be stopped. SSD stated he/she gave them their last covered day, and if they remained in the facility, he/she would explain to them their rights to appeal. SSD said he/she did not document those conversations in the EMR anywhere. He/she stated if there was an RP, he/she reached out to them. He/she said a resident who had a BIMS of lower than 10 would not be appropriate to sign the forms therefore he/she spoke to the family. He/she said she spoke with R5's RP who was unable to sign and stated the RP told him/her to have R5 sign the form. SSD said when he/she spoke with R32, he/she refused to sign the form but did not document that conversation in the EMR. SSD stated he/she usually documented that on the form, but he/she did not on R32's and he/she was unsure why he/she did not. During an interview on 01/15/26 at 2:05 PM, the Director of Nursing (DON) stated he/she was not clinical and did not want to provide his/her expectations related to something not clinical. Review of the facility's policy titled, (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Advanced Beneficiary Notices, revised 09/25 revealed it is the policy of the facility to provide timely notices regarding Medicare eligibility and coverage. NJAC 8:39-5.1(a)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to develop a care plan for one of two residents (Resident (R) 11) reviewed for behavioral-emotional status of 27 sample residents. This failure could interfere with the resident receiving proper psychological services to help maintain a comfortable, safe life. Findings include:Review of R11's admission Record located in the Profile tab of the electronic medical record (EMR) revealed he was initially admitted to the facility on [DATE] and readmitted on [DATE] with major depressive disorder, anxiety disorder, and post-traumatic stress disorder (PTSD), chronic. Review of R11's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/14/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R11 had intact cognition. The MDS also indicated R11 had diagnosis of PTSD. Review of R11's CAA [Care Area Assessment] Worksheet, dated 09/11/25, revealed R11's mood interview triggered an actual problem/need related to PTSD. Review of R11's Care Plan, under the care plan tab of the EMR, revealed there were no care plans addressing R11's diagnosis of PTSD.During an interview on 11/21/25 at 1:05 PM, the Director of Nursing (DON) stated he/she should have created a care plan for R11's PTDS diagnosis. The DON stated R11 saw a psychiatrist and acknowledged that because the diagnosis was listed on the comprehensive assessment and on his face sheet. The DON stated they should have created a care plan. Review of the facility's policy titled, Comprehensive Care Plans, dated 08/25, revealed It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial need that are identified in the resident's comprehensive assessment. NJAC 8:39-11.2(e) thru (i)NJAC 8:39-27.1(a)

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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** Based on observation, interview, record review, and policy review, the facility failed to ensure residents who were assessed as requiring an apron were provided with an apron while smoking for one of two residents (Resident (R) 105) reviewed for smoking out of 27 sampled residents. This has the potential to affect all residents who smoke. Findings include:Review of R105's admission Record in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnosis of unspecified disorders of the brain.Review of R105's admission Minimum Data Set (MDS) under the Minimum Data Set (MDS) tab of the EMR revealed an assessment was still in progress. No Assessment Reference Date (ARD) available. Review of R105's Care Plan located under the Care Plan tab of the EMR, dated 01/10/26, revealed R105 was care planned for addiction to nicotine. Interventions in place were that the resident required supervision while smoking. Review of R105's Nursing admission Assessment located under Assessments tab in the EMR, dated 01/12/26, revealed R105 was high risk for smoking and required an apron while smoking. During observations on 01/14/26 at 10:00 AM and 2:00 PM revealed R105 smoking without an apron. During an interview on 01/14/25 at 2:18 PM, the Activities Director (AD) stated all residents who wanted to smoke were assessed on admission or when they informed staff they wished to smoke. The AD stated nursing completed the assessment and would verbally inform him/her when a resident required an apron. The AD stated he/she had access to review the smoking assessments, but he/she did not review R105. He/she said Subacute Unit Manager ([NAME]) informed him/her R105 was a safe smoker and did not require an apron while smoking. The AD said he/she was unaware R105's assessment indicated he/she was high risk or that he/she required an apron. During an interview on 01/14/26 at 2:40 PM, the [NAME] stated he/she did not remember telling the AD that R105 was assessed as a safe smoker. He/she reviewed the smoking assessment, dated 01/12/26, and agreed it indicated he/she was a high-risk smoker and required an apron. He/she said based on the assessment he/she should be wearing an apron and not smoking without one. During an interview on 01/15/26 at 2:05 PM the Director of Nursing (DON) stated a smoking assessment was completed for all residents wishing to smoke. The DON stated nursing staff would communicate that information to the activity's director and that the information on the assessment should be followed if they did or did not require adaptive equipment while smoking. He/she said the interdisciplinary (IDT) team should have reviewed R105's smoking assessment along with the AD. He/she said patient safety had to be maintained and that he/she expected whatever was on the assessment to be followed or if there was any discrepancy that should be addressed prior to a resident smoking. The DON said when he/she completed R105's assessment she clicked the wrong button, but it was not reviewed, and it should have been. Review of the facility's policy titled, Resident Smoking Policy, revised 10/25, revealed this facility provides a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Residents who smoke will be further assessed, using the Safe Smoking Evaluation to determine whether or not supervision is required for smoking, or if resident is safe to smoke at all. NJAC 8:39-5.1(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure residents received alternative measures prior to the installation of side rails; for one of four residents (Resident (R) 105) reviewed for side rails out of 27 sampled residents. The lack of alternate side rail measures and proper assessment/consent could lead to potential restraint or side rail entrapment. Findings include:Review of R105's admission Record in the Profile tab of the electronic medical record (EMR) revealed he was admitted to the facility on [DATE] with diagnosis of unspecified disorders of the brain.Review of R105's admission Minimum Data Set (MDS) assessment under the MDS tab of the EMR revealed an assessment was still in progress. The Assessment Reference Date (ARD) was not available. Review of R105's Care Plan located under the Care Plan tab of the EMR, dated 01/10/26, revealed R105 was care planned for 1/4 side rail use. Review of R105's Physician Orders located under the Orders tab in the EMR, dated 09/08/25, revealed,1/2 side rails per resident request and to promote a sense of security and to assist with transfers and bed mobility.Review of R89's Nursing admission Assessment located under Assessments tab in the EMR, dated 01/10/26, revealed no documentation that alternates were explored prior to bed rail/side rail use.During observations on 01/12/25 and 01/13/25, there were side rails on both sides of R105's bed. During an interview on 01/15/26 10:20 AM the Subacute Unit Manager ([NAME]) stated on admission, staff would assess for repositioning, and their mobility. The [NAME] stated he/she thought there was a process to assess alternates before, but it has been a while. He/she said they didn't complete the process of exploring alternatives, and he/she was unsure if that was part of the current process. He/she stated all side rails in the facility were already on the bed for resident use. During an interview on 01/15/26 at 2:05 PM, the Director of Nursing (DON) said side rails were on all the beds. The DON stated there was an assessment completed and they got the consent from the resident or responsible party. He/she stated if they did not give consent; the side rails were removed. He/she stated side rails were used as enablers and were only 1/4. He/she said they were not used as a restraint, and staff did not look at alternatives since they were not used as restraints. Review of the facility's policy titled, Proper Use of Side Rails, revised 11/25, revealed the purpose of these guidelines is to ensure the safe use of side rails as resident mobility aides and to prohibit the use of side rails as restraints. NJAC 8:39-27.1(a)