STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

[X1] PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER
[315094]

[X2] MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____

[X3] DATE SURVEY COMPLETED
12/31/2018

NAME OF PROVIDER OF SUPPLIER
MERCERVILLE CENTER

STREET ADDRESS, CITY, STATE, ZIP
2240 WHITEHORSE-MERCERVILLE ROAD MERCERVILLE, NJ 08619

For information on the nursing home’s plan to correct this deficiency, please contact the nursing home or the state survey agency.

(LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER’S SIGNATURE)

[NJAC 39:4-1.1(a)]

2. The surveyor reviewed Resident #3’s medical record which reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. The initial MDS dated [DATE] reflected that the resident had no cognitive impairment, and required two person assistance with transfer. The quarterly MDS dated [DATE], also indicated that Resident #3 had no cognitive impairments.

A nurse’s note dated 5/23/18 indicated that Resident #3 was hospitalized on [DATE] and re-admitted to the facility on [DATE]. The nurse’s note dated 10/12/18 at 3:05 PM, indicated that Resident #3 was admitted to the hospital with [REDACTED].

The nurse’s note dated 10/15/18 at 9:27 PM, reflected the resident was re-admitted back to facility on 10/15/18. There was no documentation in the medical record that the resident’s representative or the Ombudsman representative were notified in writing regarding this hospitalization.

The surveyor noted that two days after the resident was admitted to the facility, there was another order dated 11/2/18, for Trazadone (classified as anti-depressant ) 50 mg daily at night for the [DIAGNOSES REDACTED]. The MDS also indicated that Resident #36 required two person assistance with transfers, did not walk, and was on an anti-psychotic medication.

On 12/24/18 at 12:05 PM, the surveyor observed Resident #36 who was in the dining room and being assisted by a staff member for lunch. The surveyor reviewed the progress note dated 8/20/18 at 10:46 PM, which reflected that Resident #36 was readmitted to the facility from the hospital. A Progress note dated 8/15/18 at 5:23 PM indicated that the resident was sent to the hospital after the resident vomited a large amount and that the resident’s family was notified. There was no documentation in the medical record that the resident’s representative or the Ombudsman representative were notified in writing regarding this hospitalization.

A nurses’s note dated 5/23/18 indicated that Resident #3 was hospitalized on [DATE] and re-admitted to the facility on [DATE]. The nurse’s note dated 10/12/18 at 3:05 PM, indicated that Resident #3 was admitted to the hospital with [REDACTED].

The nurse’s note dated 10/15/18 at 9:27 PM, reflected the resident was re-admitted back to facility on 10/15/18. There was no documentation in the medical record that the resident’s representative or the Ombudsman representative were notified in writing regarding these hospitalizations.

During an interview with the Director of Nursing (DON) and the Administrator on 12/24/18 at 11:14 AM, the Administrator mentioned that they were not aware of the new requirement until recently. The DON stated that the social worker had only been employed for one month and may not have sent the information to the family and Ombudsman.

On 12/24/18 at 11:14 AM, the surveyor reviewed a one page document which the DON stated was a sample list that would be sent to the resident’s representative. The DON verbalized that the facility did not send a written notification. The DON then provided a two page document titled, Discharge and Transfer (OPS 404) which had a revision date of 03/12/19. The document reflected that the facility will notify the resident’s representative verbally, followed by written notification and that a copy of the notification was to be sent to the Ombudsman.

F 0623
Level of harm - Minimal
harm or potential for actual harm
Residents Affected - Few

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

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 of survey whether or not a plan of correction is provided.

F 0758
Level of harm - Minimal
harm or potential for actual harm
Residents Affected - Few

Implement gradual dose reductions (GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.

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 of survey whether or not a plan of correction is provided.
RESIDENTS AFFECTED - FEW

The Care Plan dated 10/31/18, reflected that the resident was on [MEDICATION NAME] and Lorazepam (MEDICATION NAME).
The Care Plan did not specify or indicate what targeted behaviors the resident exhibited or if the resident had [MEDICAL CONDITION].

On 12/31/18 at 10:20 AM, the Director of Nursing (DON) confirmed that staff did not document Resident #53's behaviors to support the additions of the two [MEDICAL CONDITION] medications on 11/28/18.

A review of the Medication Administration Record (MAR) dated 12/18/18, reflected an order for [REDACTED]. The surveyor noted that staff signed that they administered the [MEDICATION NAME] gel twice a day from 12/20/18 through 12/28/18 but staff did not document the times that the [MEDICATION NAME] gel was administered.

On 12/18/18 at 9:00 AM, the resident's primary care Licensed Practical Nurse (LPN) who stated that the resident was exhibiting behaviors during care, I would then administer the [MEDICATION NAME]. The LPN added, I don't know why there is no documentation of behaviors to support the reason for Trazodone or [MEDICATION NAME]. The LPN did not provide evidence of other non-pharmacological interventions used before the additions of the additional psychoactive medications and did not indicate the assessment conducted by the facility to understand the reason behind the resident's behaviors.

The surveyor reviewed the Behavior Monitoring and Interventions form (BMI) dated (MONTH) (YEAR). This reflected that Resident #53 had targeted behaviors that included: screaming at others, agitation, [MEDICAL CONDITION] (difficulty sleeping), and resistance to care. The BMI also indicated that the resident did not exhibit the behavior of resistance to care during the month of (MONTH) (YEAR), but exhibited screaming at others three times and agitation 12 times. The facility could not explain what agitation meant.

The surveyor reviewed the BMI for the month of (MONTH) (YEAR) which reflected that Resident #53 exhibited the behavior of resistance to care three times on 11/28/18, but did not exhibit any other behaviors during the month of (MONTH) (YEAR).

There was no supporting documentation in the medical record to show why Resident #53 required to be medicated with a psychoactive medication before providing routine care for the resident.

A review of the MAR dated 12/18/18, reflected that the [MEDICATION NAME] gel was administered three times on 12/20/18 instead of the twice a day. The information on the declining inventory were as follows:

- 12/25/18 at 8:00 AM
- 12/24/18 at 8:00 AM
- 12/24/18 at 9:00 PM
- 12/23/18 at 8:00 AM
- 12/23/18 at 9:00 PM
- 12/22/18 at 9:00 PM
- 12/22/18 at 8:00 AM
- 12/21/18 at 8:00 AM
- 12/21/18 at 9:00 PM
- 12/20/18 at 11:00 PM
- 12/20/18 at 9:00 PM
- 12/20/18 at 8:00 AM
- 12/20/18 at 8:00 AM
- 12/20/18 at 8:00 AM

There was no explanation or corresponding documentation provided by the facility regarding the times care was provided on the above days and the behaviors Resident #53 presented to warrant the administration of the [MEDICATION NAME] gel. There was also no explanation provided to show why the [MEDICATION NAME] gel was administered three times on 12/20/18. On 12/31/18 at 9:49 AM, the surveyor interviewed the primary care LPN who stated that she administered the [MEDICATION NAME] gel when the resident exhibited the behaviors of refusal of care, talking loudly and waving his/her hands about. The LPN stated, I administered the [MEDICATION NAME] gel 0.5 mg, apply 1 ml topically to inner wrist prior to AM and PM care daily. There was no supporting documentation in the medical record to show why Resident #53 required to be medicated with a psychoactive medication before providing routine care for the resident.

The surveyor reviewed the [MEDICATION NAME] gel order was clarified on 12/18/18 and reflected, [MEDICATION NAME] Gel 0.5 mg, apply 1 ml to inner wrist prior to AM and PM care daily. There was no supporting documentation in the medical record to show why Resident #53 required to be medicated with a psychoactive medication before providing routine care for the resident.

There was also no evidence of other interventions attempted around the provision of the resident's routine AM and PM care.

On 12/31/18 at 10:06 AM, the surveyor interviewed the primary care CNA who stated that the resident's behavior fluctuated during care and the LPN also added that the resident would cry and need to be medicated. The surveyor reviewed Resident #53's (MONTH) (YEAR) POS which indicated that [MEDICATION NAME] (classified as an anti-psychotic medication) 5 mg was ordered on [DATE] at bedtime for the resident to treat Dementia with Behavior Disturbance.

The surveyor reviewed the BMI from (MONTH) (YEAR) until (MONTH) (YEAR) and noted the forms to be blank and did not reflect that the resident exhibited or had behaviors during that time. On 12/28/18 at 12:15 PM, the surveyor interviewed Resident #53 who stated that she/he was diagnosed with [REDACTED]. The
Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure medication error rates are not 5 percent or greater.

Based on the observation, interview, and record review, it was determined that the facility failed to maintain a medication error rate below 5%. During the medication pass, the surveyor observed 1 of 3 nurses administer 28 medications to 7 residents. There were no errors noted. The resident who was administered medication was not observed or identified. The facility's policy on medication error rates is not reviewed at least annually.

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide and implement an infection prevention and control program.

Provide the appropriate handwashing technique during the medication pass and follow the appropriate infection control protocol when entering rooms with isolation precautions and providing resident care. This deficient practice was identified for 1 of 3 nurses observed and for three staff members during the medication pass and was reported by the following: 1. The surveyor conducted a medication pass observation on 12/28/18 and observed a Licensed Practical Nurse (LPN) on the South Wing administer [MEDICATION NAME] 1 mg (milligram) to Resident #26. The [MEDICATION NAME] was scheduled for 9 AM and 5 PM daily. The [MEDICATION NAME] was given two hours after the scheduled time of administration of 9 AM. Late administration of the medication also does not allow for the eight-hour separation between the morning and evening doses. At that time, the surveyor attempted to interview Resident #26 but the resident was non-verbal. The surveyor reviewed Resident #26's annual MDS, an assessment tool used to facilitate care, dated 10/19/18, which showed that the resident was admitted with [DIAGNOSES REDACTED]. On 12/26/18 at 11:20 AM, the surveyor observed the same LPN administer medications to Resident #37. The medications included Tegretal (treats [MEDICAL CONDITION]) 10 ml (milliliter), which was scheduled for 9 AM and 6 PM daily, and [MEDICATION NAME] (treat high blood pressure) 2.5 mg, which was scheduled for 9 AM and 5 PM daily through the gastrostomy tube. The [MEDICATION NAME] (treat [MEDICAL CONDITION]) were given two hours later than the scheduled time of administration. Late administration of the medications also does not allow for the eight-hour separation between the morning and evening doses. At that time, the surveyor attempted to interview Resident #37 but the resident was unable to be interviewed due to cognitive impairment.

A review of Resident #37's 10/31/18 quarterly MDS revealed that the resident was admitted with medical [DIAGNOSES REDACTED]. On 12/26/18 at 11:35 AM, the surveyor interviewed the LPN regarding the administration of medications outside the scheduled times. The LPN stated that she had one resident for whom she provided [MEDICAL CONDITION] care earlier and that it took a lot of her time. She asked about the facility protocol for giving medications outside of scheduled times, and the LPN replied that it depends on the medication. If the medication had parameters, she would notify the pharmacist about being late with the medication. If there was no indication of how long Tegretal and [MEDICATION NAME] should have been considered to be at risk, the LPN stated that these medications would not have necessitated a call to a physician because the two medications did not have parameters. The surveyor noted that the nurse signed out all the medication on the Medication Administration Record [REDACTED]. There was no further documentation on the MAR indicated. On 12/31/18 at 11:00 AM, the Director of Nursing stated that the nurse should have notified the pharmacist about the late administration of medications for Resident #37 and #62. On 12/31/18, the surveyor reviewed the facility policy on medication administration titiled, Medication Administration: General, which reflected that doses will be administered within one hour of the prescribed time unless otherwise indicated by the prescriber. NJAC 8:39-29.2(d)

Based on the observation, interview, and record review, it was determined that the facility failed to: a) place the appropriate handwashing technique during the medication pass and b) follow the appropriate infection control protocol when entering rooms with isolation precautions and providing resident care. This deficient practice was identified for 1 of 3 nurses observed and for three staff members during the medication pass and was reported by the following: 1. The surveyor conducted a medication pass observation on 12/28/18 and observed a Licensed Practical Nurse (RN) on the North wing as she administered medications to Resident #22 and Resident #60. On 12/26/18 at 9:00 AM, the surveyor observed the RN wash her hands for 12 seconds under running water after administration of medications. At 9:05 AM, the RN washed her hands again under the running stream of water for 5 seconds. On 12/26/18 at 9:17 AM, the surveyor reviewed the RN regarding hand washing. The RN stated that she was not sure what the facility policy was. The surveyor asked her if she usually washed her hands for 20 seconds and the RN replied that she did not know why the one minute hand wash was not followed and the RN responded that she did not know. On 12/26/18 at 10 AM, the surveyor interviewed the Infection Control Coordinator and stated that the facility followed the CDC guidelines of scrubbing hands for two then rinsing. Then she added that staff were trained on proper hand washing technique and should know. The surveyor reviewed facility documentation that showed that the facility provided in-service education on hand washing on 12/11/18. On 12/31/18, the surveyor reviewed the policy titled, Hand Hygiene, with a revision date of 3/1/18. The policy revealed that staff should apply soap to hands, and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. This policy was not followed by the nurse. 2. The surveyor reviewed the Admission Record dated 12/31/18 which reflected that Resident #201 was admitted to the facility with medical [DIAGNOSES REDACTED]. According to the Minimum Date Set (MDS), an assessment tool used to facilitate care, dated 12/24/18, the resident was cognitively intact and answered questions appropriately. On 12/20/18 at 9:36 AM, the surveyor observed an isolation cart set up outside Resident #201's room on the South wing. The
### Statement of Deficiencies and Plan of Correction

#### (X1) Provider / Supplier / CLIA Identification Number
- **Provider / Supplier**: Mercerville Center
- **CLIA ID Number**: 315094

#### (X2) Multiple Construction
- **Building**:__
- **Wing**:__

#### (X3) Date Survey Completed
- **12/31/2018**

#### Name of Provider of Supplier
- **Mercerville Center**

#### Address
- **2240 Whitehorse-Mercerville Road
Mercerville, NJ 08619**

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For information on the nursing home’s plan to correct this deficiency, please contact the nursing home or the state survey agency.

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### Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

- **Event ID**: YL1O11
- **Facility ID**: 315094
- **Previous Versions Obsolete**
- **Page 4 of 4**

#### F 0880
- **Level of harm**: Minimal harm or potential for actual harm
- **Residents Affected**: Few

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>12/20/18</td>
<td>On 12/20/18 at 9:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who was at the nursing station. The LPN stated that Resident #201 had [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA) (a contagious bacteria that is resistant to many antibiotics that are used to treat bacteria infections) of the sputum.</td>
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<td>On 12/20/18 at 9:45 AM, the surveyor observed the primary care LPN enter Resident #201’s room without wearing PPE. The LPN then removed the resident's food tray and walked out of the resident's room. The LPN then placed the resident's tray on the food truck and went to the medication cart to prepare medications, without performing hand washing in between.</td>
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<td>On 12/20/18 at 9:51 AM, the surveyor observed the Certified Nursing Assistant (CNA) enter Resident #201's room to answer the call light. The CNA did not apply the PPE before entering the room.</td>
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<td></td>
<td>On 12/20/18 at 9:48 AM, the surveyor observed the Certified Nursing Assistant (CNA) enter Resident #201's room to retrieve the food tray and that she should have worn the PPE before entering the resident's room.</td>
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<td>On 12/20/18 at 10:10 AM, the surveyor interviewed Resident #201 who stated that some staff wore the PPE and some did not. The resident stated, not all staff wear the PPE when they come into my room.</td>
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<td>On 12/20/18 at 10:43 AM, the surveyor observed the medical supply employee go into the Resident #201’s room to answer the call light. The employee did not apply PPE before entering the room.</td>
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<td>On 12/20/18 at 11:21 AM, the surveyor interviewed the CNA who stated that she only went into Resident #201’s room for a minute so she didn't think that she had to wear the PPE. The CNA stated, I was only in the room for a minute and I only peeked behind the curtain and then left the room.</td>
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<td>On 12/20/18 at 11:30 AM, the surveyor interviewed the Registered Nurse Unit Manager who stated that all staff should wear PPE when entering the resident's room.</td>
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<td>The facility policy dated 11/15/18 and titled, Droplet Precautions and Respiratory Hygiene/Cough Etiquette, indicated that gloves and gown as well as goggles/face shield should be worn.</td>
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<tr>
<td>12/28/18</td>
<td>On 12/28/18 at 9:42 AM, the surveyor observed a CNA after providing care to a resident in room [ROOM NUMBER] on the South wing. After providing care to the resident, the CNA was observed exiting room [ROOM NUMBER] while wearing the same gloves that were used on the resident.</td>
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<tr>
<td></td>
<td>On 12/28/18 at 9:42 AM, the surveyor observed a CNA after providing care to a resident in room [ROOM NUMBER] on the South wing. After providing care to the resident, the CNA was observed exiting room [ROOM NUMBER] while wearing the same gloves that were used on the resident. The surveyor observed the CNA obtain clean linens off the clean linen cart while wearing the same gloves and then return to room [ROOM NUMBER] and continue with the resident's care.</td>
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<td></td>
<td>The surveyor observed the resident to [ROOM NUMBER] and observed the CNA as she provided incontinence care to the resident. The surveyor observed a soiled wash cloth soiled with bowel movement and a hospital gown, which the CNA had placed directly on the floor. At that time on 12/28/18 at 9:42 AM, the surveyor observed the CNA who stated that she knew that she should have taken her soiled gloves off before touching the clean linen cart, but she was in a rush. The CNA also confirmed that she had thrown the soiled wash cloth and gown directly on the floor. She stated, I shouldn't have done it, but what do you want me to do about that now? I couldn't reach the plastic bag because it was on the other side of the bed. The surveyor reviewed the Infection Prevention and Control Program Description which had a revision date of 3/1/18 and this did not address the use of PPE.</td>
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<td>N.J.A.C. 8:39-19.1</td>
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