STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060315	A. BUILDING: _____ B. WING _____	06/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARCELLA CENTER	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan; or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.	S2315		7/21/17

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

Electronically Signed | 06/30/17

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S2315	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on documentation review on 6/15/17 in the presence of facility management, it was determined that the facility failed to meet with municipal and county emergency management officials Annually to review and update the emergency evacuation plan. This deficient practice was evidenced by the following: A review of the facility's disaster plan review documentation revealed that the facility sent the plan to emergency management officials (OEM) and were reviewed on 9/20/16. The review letter stated that there were updates necessary to the plan and the facility needed to correct and resubmit it for approval. The facility had not updated the plan or resubmitted it to OEM for approval as of the date of survey, nearly 9-months later.	S2315	1 The Administrator will meet with the county and municipal management coordinators to review and update the emergency evacuation plan. 2 No residents were identified in this deficiency. This has the potential to affect all residents. 3 A new Maintenance Supervisor was hired in June. The Administrator provided training to the new supervisor on this requirement and assigned this responsibility to the Supervisor. 4 The Administrator will review the Emergency manual bi annually to ensure that it is up to date.	

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F 000	INITIAL COMMENTS STANDARD SURVEY: 6/15/17 CENSUS: 148 SAMPLE SIZE: 24	F 000		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than	F 278		7/14/17

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

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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.

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F 278	Continued From page 1 $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to document resident's information in the Minimum Data Set (MDS), a resident assessment tool. This deficient practice was identified for 1 of 5 residents reviewed for behavior, Resident #20, as evidenced by the following: On 6/11/17 during the initial tour the nurse told the surveyor that Resident #20 had behaviors of wandering aimlessly about the unit. The resident was not in the room at that time. On 6/14/17 at 9:45 a.m., the surveyor observed the resident walking about the unit unsupervised. The resident appeared calm and in no apparent distress. On 6/14/17 at 10:30 a.m. the surveyor reviewed the resident clinical record. Both the Annual and the Quarterly MDS dated respectively [redacted] and [redacted] indicated that the resident did not exhibit any behavior. The section [redacted] referred to "Wandering" was coded as 0 indicated that the resident did not exhibit the behavior. However, the wandering behavior was documented daily on the Progress Notes. On 6/14/17 at 11:00 a.m. the surveyor reviewed Resident #20 records which indicated that the resident wandered daily on the unit.	F 278	1 The Clinical Reimbursement Coordinator corrected the MDS assessment to reflect wandering for resident # 20. 2 This has the potential to affect all residents who wander. The Unit Managers reviewed the nurses notes to determine which other residents had wandering behavior. The Social Worker reviewed the MDS assessments to ensure accuracy of the assessments. 3 The Unit Manager inserviced the nurse on procedure for completion of the expanded assessment, which includes reviewing the resident notes prior to completion of assessment. The NPE provided an inservice to nursing staff on expanded assessment. 4 The Clinical Reimbursement Coordinator attends the daily meeting and reviews the nurses notes along with the Unit Manager and the IDC team.The Clinical Reimbursement Coordinator will audit 3 assessments per month for 3 months and will identify discrepancies. The CRC will submit findings to the Quality Assurance Committee. The committee will	

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F 278	Continued From page 2 On 6/15/17 at 11:30 a.m., the surveyor interviewed the Certified Nursing Assistant (CNA), who cared for the resident. The CNA revealed that the resident was combative, was ambulatory and wandered constantly. On 6/15/17 at 11:35 a.m., the surveyor interviewed the UM regarding the resident's wandering behavior. The UM stated "the resident wanders, we will turn her back and redirect. Everybody is aware." On 6/15/17 at 12:30 p.m., the surveyor interviewed the Social Worker (SW) responsible for the coding of section E of the MDS. The SW stated "Wandering is normal for this resident so I may have missed that. It should be documented. I will look through the notes more carefully. I know he/she wanders all the time." The surveyor asked if the resident should be coded as a wanderer? The SW stated "yes, she should be coded as a wanderer as per MDS criteria." NJAC 8:39-11.2 (1)	F 278	implement further corrective actions as warranted by the audit.	

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F 278	Continued From page 3	F 278		
F 281 SS=D	a SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		7/14/17

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F 281	Continued From page 4 Based on observation, interview and record review it was determined that the facility failed to provide care and services according to Physician's order and failed to follow standards of Professional Practice in regards to documentation . This deficient practice was identified for Resident #12, 1 of 24 residents reviewed for care and services as evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." During the initial tour of the facility on 6/11/17 at 9:30 a.m., the nurse told the surveyor that resident #12, was awake, alert and oriented. At that time the surveyor observed the resident in bed. On 6/12/17 at 9:00 a.m., the surveyor observed the resident in bed, his/her eyes were closed and his/her feet were rested directly on the mattress. On 6/12/17 at 9:45 a.m. the surveyor reviewed the resident's clinical record which revealed that the resident had diagnoses which included [redacted], [redacted]. Further review of the clinical record revealed a physician order dated[redacted] with an original date	F 281	1 The Nurse applied the [redacted] device to resident # 12. 2 This has the potential to affect all residents who have orders for [redacted] devices. The Unit Managers reviewed treatment records and physician orders of all residents to determine which residents had orders for [redacted] devices. The Unit Managers ensured that all residents with orders had devices in place. 3 The Unit Manager counseled the nurse regarding the procedure for completing treatment orders. The Unit Manager educated the nursing assistant about following the plan of care pertaining to the [redacted] device. The procedure includes monitoring the placement of the device prior to signing off as complete. The Nurse Practice Educator provided an inservice to nurses and nursing assistant regarding placement of [redacted] devices. 4 The Unit Manager will make rounds monthly for 3 months to observe residents with [redacted] devices. The Unit Manager will take corrective action at the time of the rounds and will record findings. The Unit Manager will present finding to the Quality Assurance Committee quarterly. The committee will	

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F 281	Continued From page 5 of [redacted] for "[redacted] Devices to be donned on [redacted] while in bed. Remove for cleansing as needed." The surveyor observed the resident in bed on the following dates: 6/12/17 at 9:00 / 6/13/17 at 10:00 a.m. and 6/14/17 at 9:30 a.m. his/her[redacted] rested directly on the mattress. On 6/13/17 at 10:30 a.m. the surveyor interviewed the Certified Nursing Assistant (CNA) who cared for the resident that day, the CNA was unaware of the order for the [redacted] Devices. An interview with the resident on 6/14/17 at 9:30 a.m. revealed that the the [redacted] Devices were lost and he/she had not wore them for awhile. On 6/14/17 at 10:45 a.m. the surveyor reviewed the Treatment Administration Record (TAR) for the month of June and noted that the TAR had been signed by the nurse even on the dates that the [redacted] Device were not being applied. On 6/14/17 at 11:30 a.m. the surveyor interviewed the nurse regarding the [redacted] Device. The nurse told the surveyor that the Device was being removed for care. The surveyor then escorted the nurse to the resident's room where we both observed the resident in bed with the [redacted] rested on the mattress. The nurse was unable to locate the [redacted] Device. The nurse told the surveyor that she assumed that the [redacted] Device was in place but did not check them before signing the TAR.	F 281	implement further corrective actions as warranted by the audit.	

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F 281	Continued From page 6 On 6/14/17 at 10:50 a.m., the surveyor interviewed the Unit Manager/Registered Nurse regarding the [redacted] Device for Resident#12. The UM was not aware the [redacted] Device was an issue until brought to her attention by the surveyor. The UM went to the Resident's room and located the [redacted] Device in the Residents closet in a sealed plastic bag. The UM and LPN applied the [redacted] Device to Resident #12's [redacted] at this time. On 6/14/14 at 10:55 a.m., in the presence of the UM, the surveyor interviewed CNA #2 who stated "I checked at 9:30 a.m., this morning and did not see any Heels Suspension Device on the resident's feet today."	F 281		
F 431 SS=D	NJAC 8:39-11.2(b) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS CFR(s): 483.45(b)(2)(3)(g)(h) The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 431		7/14/17

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F 431	Continued From page 7 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record	F 431	1	

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F 431	Continued From page 8 reviews it was determined that the facility failed to label, date and remove expired medications from the medication carts and refrigerator. This deficient practice was identified for four of eight medication carts and one of four refrigerators identified during the initial tour as evidenced by the following: On 6/11/17 at 7:45 a.m. the surveyor inspected the medication cart on the [redacted] in the presence of the unit nurse and noted one bottle of [redacted] in the refrigerator open and not dated. One bottle of [redacted] open and not dated. An interview with the nurse at 7:55 a.m. revealed that all medication and [redacted] should be dated once open. At 8:05 that same day the surveyor inspected the Unit [redacted] medication cart and noted the following on cart one: Five [redacted], open and not dated. One [redacted] open 4/27/17. One [redacted] open 5/5/17. One [redacted] open 5/13/17. One bottle of [redacted] open and not dated. One bottle of [redacted] tablet open and not dated. According to the nurse all [redacted] should be dated and discarded based on the manufacture's specification. At 8:20 a.m. the second cart was noted with one [redacted] open and not dated. The surveyor inspected the [redacted] medication cart at 8:30 a.m. with the nurse and noted the	F 431	The Unit Managers discarded the medication and [redacted] that was not dated or outdated. 2 No specific residents were identified in this deficiency. This has the potential to affect all residents. The Unit Managers checked all medication refrigerators, carts, and storage areas to ensure all medications were dated and maintained according to manufacturer's specifications. 3 The Nurse Practice Educator provided an inservice for the nurses on dating and storage of medication according to manufacturers specifications. 4 The Unit Managers will visually inspect the medication carts, refrigerators and storage areas weekly for 3 months. The Unit Manager will make corrections at the time of the audit and will record findings. The Unit Manager will present findings quarterly to the Quality Assurance Committee. The committee will implement further corrective actions as warranted by the audit.	

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F 431	Continued From page 9 following: Two [redacted] open and not dated. One [redacted] open and not dated. One [redacted] open and not dated. One [redacted] bottle open and not dated. One [redacted] open and not dated. In the refrigerator one bottle of [redacted] was noted open and not dated. An interview with the nurse at 8:40 a.m. revealed that according to the facility's protocol all [redacted] should be dated when they are opened. The facility was made aware of the above findings on 6/12/17 at 1:30 p.m. On 6/13/17 at 12:30 p.m. the nurse Educator informed the team that all the nurses were in-serviced on 5/17/17 by the Pharmaceutical Company regarding dating and labeling medications once open. NJAC 8:39-27.1 (a), 29.4 (2)	F 431		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.90(i)(5) (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by:	F 465		7/14/17

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F 465	Continued From page 10 Based on observation, interview and record review it was determined that the facility failed to monitor the temperature of pantry refrigerators used to store residents' food. This deficient practice was identified in 2 of 3 units, [redacted] and [redacted] as evidenced by the following: On 6/12/17 at 10:37 a.m. the surveyor observed that the thermometer in the refrigerator on Unit [redacted] registered 48 degrees Fahrenheit (F). At that time, there were six 4 oz. containers of milk and one 8 oz. milk carton stored on the shelf of the refrigerator door. The rest of the refrigerator was used to store staff lunches. At 11:07 a.m. that day, the surveyor observed that the Unit [redacted] refrigerator temperature had risen to 52 degrees F. The surveyor asked the Unit Manager (UM) if there was a log to record the refrigerator temperature. She replied that there should be a log and began to search for one. At 11:24 a.m. on 6/12/17, using a calibrated thermometer, the surveyor checked the temperature of one of the 4 oz. containers of milk stored in the Unit [redacted] pantry refrigerator in the presence of the Director of Nursing (DON) and a Corporate representative. The temperature of the milk from the Unit [redacted] refrigerator registered 52 degrees F. On 6/12/17 at 11:30 a.m. the surveyor checked for pantry refrigerator temperature logs on Unit [redacted] and the [redacted] Unit. Both of these refrigerators had thermometers that registered an acceptable temperature of 40 degrees F. Only the [redacted] Unit nursing staff had been recording the daily pantry refrigerator temperature on a log. The UM on Unit [redacted] could	F 465	1 The items that were stored in the refrigerators were discarded. 2 No residents were identified in this deficiency. This has the potential to affect all residents. The Unit Managers checked their refrigerators to ensure the temperatures were within guidelines. 3 The Nurse Practice Educator provided an inservice for the nurses on recording temperatures of refrigerators daily. The NPE provided the nurses with a form to record temeperatures. 4 The Unit Manager will inspect the form weekly to ensure that temperatures are recorded daily. The Unit Manager will take action at the time of the review. The Unit Manager will record findings monthly for 3 months and will report findings to the Quality Assurance Committee quarterly. The Quality Assurance Committee will implement further corrective actions as wannranted by the audit.	

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MARCELLA CENTER	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 11 not produce a current daily log. On 6/12/17 at 12:00 p.m. the Administrator told the surveyor that they had two policies regarding monitoring of refrigerator temperatures. (Neither specified checking unit pantry refrigerators.) One policy was intended for monitoring the refrigerators in the dietary department. The other referred to checking medication refrigerators. The Administrator said, "We just have to decide which one to use." He acknowledged that the refrigerators were used for staff and "some left-over items." For example: If a resident refused a snack or a resident's family brought in food, it would be stored in the unit pantry refrigerator. The DON added that the 11-7 nursing shift recorded the temperature of the pantry refrigerators. On 6/13/17 at 10:40 a.m. the DON showed the surveyor refrigerator logs from the unit pantries with the most recent log dated from January, 2017. "Then we stopped." On 6/14/17 at 2:00 p.m. the Corporate representative explained that "We changed our forms in January." The new forms specified "Medication and Vaccine" on the top. Some of the nurses recorded the temperature of the medication refrigerators, but stopped recording the resident pantry refrigerator temperatures at that time.	F 465		
F 466 SS=C	8:39-31.6 (a) and (b) PROCEDURES TO ENSURE WATER AVAILABILITY CFR(s): 483.90(i)(1) The facility must--	F 466		6/23/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315330	A. BUILDING _____ B. WING _____	06/15/2017

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F 466	Continued From page 12 (i)(1) Establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply; This REQUIREMENT is not met as evidenced by: Based on observations and documentation review on 6/13/17 in the presence of facility management, it was determined that the facility failed to establish an effective procedure to ensure water availability in the event of an emergency. This deficient practice was evidenced by the following: A review of the facility's Emergency Operations Plan for the "Interruption of Water Supply" revealed that the facility's emergency plan was to notify the contracted water supply company to obtain the necessary water for residents. A review of the facility's agreement with the water supplier revealed that the supplier would respond within 24 hours. This plan would necessitate a 24 hour supply on-site until guaranteed delivery. A review of the facility's plan also revealed that the facility established a daily amount required for operations to be 768 gallons with additional kept on site. At 12:15 p.m., the surveyor observed that facility to have 65 gallons of water on hand in the storage room (13- 5 gallon jugs) not the 768 gallons determined by the plan.	F 466	1 The Administrator reviewed and revised the water supply policy. The Administrator procured the proper amount of water in accordance with the revised policy. 2 No residents were identified in this deficiency. This has the potential to affect all residents. 3 A new Maintenance Supervisor was hired. The Administrator reviewed the emergency supply policy with him and assigned this responsibility to him. 4 The Maintenance Supervisor will inspect the emergency water supply on a monthly basis for 3 months and will order enough to meet or exceed the required amounts. The Administrator will monitor this on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 466	Continued From page 13 NJAC 8:39-31.2(e)	F 466		