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 _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	**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 000	INITIAL COMMENTS NJ Complaint # NJ00163758, NJ00163736, NJ00166680, NJ00167359, NJ00165499, NJ00163063, NJ00165288 Survey date: 11/21/23 Census: 139 Sample size: 28 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to provide an appropriately EX Order 26.4B1 for 1 of 28 residents (Resident #44) reviewed for accommodation of needs and was evidenced by the following: On 11/13/23 at 11:10 AM, during initial tour of the facility, the surveyor observed Resident #44 resting in bed in their room. The resident was EX Order 26.4B1 , EX Order 26.4B1 to	F 558	Residents affected by deficient practice: The facility failed to ensure the residents EX Order 2 accommodated EX Orde needs. This Deficient practice was identified on one resident (Resident #44) who was observed EX Order 26.4B1 Identify those individuals who could be affected by the deficient practice:	12/21/23

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

Electronically Signed | 12/08/2023

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 558	Continued From page 1 EX Order 26.4B1 [redacted] EX Order 26.4B1 [redacted] Resident #44 informed the surveyor that their EX Order 26.4B1 from EX Order 26.4B1 and that he/she is "EX Order 26.4B1" and in a EX Order 26.4B1 and is "uncomfortable." The resident further stated that they asked the facility staff for a EX Order 26.4B1, to which they informed the resident that this was the EX Order 26.4B1 can go as it is already extended and is "the EX Order 26.4B1 ." On 11/16/23 at 11:34 AM, the surveyor observed the resident in bed in the same position as previously observed. This time the EX Order 26.4B1 of EX Order 26.4B1 had a type of padding material on it to keep the resident's EX Order 26.4B1 of the EX Order 26.4B1, which the resident confirmed was placed to EX Order 26.4B1 [redacted] ." The resident stated they requested a EX Order 26.4B1 over a year ago from a previous social worker, who has since left the facility, and had requested a couple times for a EX Order 26.4B1. The resident stated they had been at the facility for "a couple of years" and does not sleep well at night due to EX Order 26.4B1. The resident also stated that when the nursing aids provide care, they make comments such as, 'EX Order 26.4B1 EX Order 26.4B1 [redacted] On 11/16/23 at 11:44 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) and asked her to accompany the surveyor to Resident #44's room to check on the EX Order 26.4B1 and if it is appropriate for the resident's needs. Upon inspecting the bed in the presence of the surveyor, the LPN/UM confirmed	F 558	" All residents have the potential to be affected by the deficient practice. " Resident #44 was monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The EX Order for Resident #44 was replaced immediately with a EX Order 26.4B1 that accommodated the residents□ needs. " Audited all beds to ensure that all residents□ needs are accommodated. " Education provided by DON/designee to nursing, housekeeping, activity, and management staff on proper accommodation, need and preference regarding all facility residents□ needs are being met regarding EX Order 26.4B1. " Education provided by DON/designee regarding nursing staff to assess all new and transferred residents/patients will be assessed for proper accommodation, need and preference regarding proper bed size. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/designee to conduct compliance audits of all Beds to ensure they meet facility residents accommodation, need and preference. " The duration of all audits will consist of completion of one-time weekly audits x4 weeks then one-time monthly x2	

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F 558	Continued From page 2 that the EX Order 26.4B1 and that it may still be EX Order 26.4B1 for the resident, and "will bring it to the attention of the interdisciplinary team (IDT) to request a EX Order 26.4B1 to accommodate the resident's needs. On 11/16/23 at 11:59 AM, the surveyor and the Director of Nursing (DON) went to the resident's room and the DON confirmed the need for a EX Order 26.4B1 The DON stated they have had EX Order residents in the past and typically the administrator automatically orders equipment needed to accommodate resident needs. Review of Resident #44's "Admission Record" revealed the resident was initially admitted to the facility in EX Order 26.4B1 with diagnosis which included but was not limited to EX Order 26.4B1 [redacted] Review of the quarterly Minimum Data Set (MDS) (a comprehensive assessment tool) dated EX Order 26.4B1 indicated the resident had a brief interview of mental status (BIMS) score of EX Old out of EX Old indicating EX Order 26.4B1, and a height of EX Old EX Order 26.4B1 EX Order 26.4B1). On 11/16/23 at 12:56 PM, in the presence of the survey team, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated he visits this resident almost every day, and confirmed the resident appeared to be EX Order 26.4B1 ." The LNHA informed the surveyor that when medical equipment is	F 558	months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting	

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F 558	Continued From page 3 ordered, they typically are delivered the same day from the facility's vendor. The LNHA informed the surveyor that he ordered a EX Order 26.4B1 for Resident #44, and it will be delivered by the end of the day. On 11/17/23 at 9:56 AM, the surveyor observed Resident #44 laying in the EX Order 26.4B1 . The resident was EX Order 26.4B1 The Resident stated "this is so much better; I can actually EX Order 26.4B1 now. I was in the EX Order 26.4B1 for EX Order 26.4B1 , this is so much more comfortable, thank you." On 11/17/23 at 11:43 AM, the surveyor asked the Facility Maintenance Director (FMD) to measure and compare the two beds. The FMD, using his own tape measure, in the presence of the surveyor measured the EX Order 26.4B1 to be EX Order 2 inches, while the extended previous EX Order 2 measured EX Ord inches. The LNHA provided the surveyor a "Mechanical and Electrical Information" sheet indicating the EX Order 26.4B1 was delivered with specifications to meet the needs of the resident.	F 558		
F 641 SS=D	NJAC 8:39- 31.8 (c)(1) Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		12/21/23

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F 641	Continued From page 4 by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 2 residents (Resident #63) reviewed for smoking. This deficient practice was evidenced by the following: On 11/13/23 at 10:23 AM, during the tour of the facility, Resident #63 was identified by the Licensed Practical Nurse/Nurse Manager LPN/UM as a smoker. At that time the surveyor observed Resident #63 ambulating in his/her room. The resident stated that he/she went out to [redacted] four to five times a day. The surveyor reviewed the Admission Record for Resident #63 which reflected that the resident was admitted with diagnoses that included [redacted]. The surveyor reviewed the nursing quarterly assessment dated [redacted], which indicated that Resident #63 [redacted]. The surveyor reviewed the smoking assessment dated [redacted], which indicated that Resident #63 [redacted]. The surveyor reviewed the care plan initiated [redacted], which reflects that this resident may [redacted] independently. The surveyor reviewed Resident #63's Annual Minimum Data Set (MDS), an assessment tool, dated [redacted]. The section for current [redacted] use was coded as [redacted] indicating that Resident #63 does not currently [redacted].	F 641	Residents affected by deficient practice: The facility failed to ensure the assessment accurately reflected the resident□s status. This Deficient practice was identified on 1 of 2 residents (Resident #63) who was coded on their Annual Minimum Data Set (MDS) as a [redacted] when the resident is a [redacted] Identify those individuals who could be affected by the deficient practice: " All residents who smoke have the potential to be affected by the deficient practice. " Resident #63 was monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " Assessment for Resident #63 was redone and resubmitted. " Audited all smokers□ Minimum Data Sets (MDS) for assessment accuracy all noted accurate. " Administrator educated MDS Coordinator on the importance of accurate coding for smokers. " Administrator/designee educated Activity Director to immediately communicate to Administrator, Director of Nursing and MDS Coordinator if any current, transferred, or new residents	

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F 641	Continued From page 5 On 11/16/23 at 01:45 PM, the surveyor interviewed the MDS Coordinator. She stated the process to identify the resident's that EX Order 26.4B1 was to look into policy to identify EX Order 26.4B1, to look at the notes, orders and care plans to determine if the resident EX Order 26.4B1 She stated that she would have to look to determine if Resident #63 EX Order 26.4B1. It should be on the MDS if the resident does EX Order 26.4B1, and the information was on the chart. She reviewed the August Annual MDS and stated that Resident #63 was not coded for EX Order 26.4B1. She stated that the purpose of coding resident would be to paint a picture of the patient, the care plan development, and review. She stated that from what she sees, Resident #63 should have been coded as a EX Order 26.4B1 in the August MDS dated EX Order 26.4B1 A review of the facility provided policy Resident Assessment (RAI) Policy and Procedures reflects "It is the policy of the facility that the completion of the RAI shall be based on the guidelines of the RAI manual." On 11/20/23 at 12:15 PM, the Director of Nursing and Licensed Nursing Home Administrator were made aware of the Annual MDS dated EX Order 26.4B1 for Resident # 63 not having NJ Exec. Order 26:4.b.1 documented as required. NJAC 8:39-2(e)1	F 641	request to be taken outside to smoke that were not previously assessed as a smoker. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee will audit all smoker assessments to ensure accurately coded on MDS. " The duration of all audits will consist of completion of one-time weekly audits x4 weeks then one-time monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans	F 655		12/21/23

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F 655	Continued From page 6 §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details	F 655		

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F 655	Continued From page 7 of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation it was determined the facility failed to develop a person-centered baseline care plan for a EX Orde risk resident within 48 hours of admission to a facility. This deficient practice was identified in 1 of 28 residents reviewed for baseline care plans (Resident #185) and was evidenced by the following: On 11/13/23 at 11:15 AM, the surveyor reviewed facility documentation which revealed the resident left the facility against medical advice (AMA) on EX Order 26.4B1. Review of the Admission Record indicated that the resident was admitted to the facility with medical diagnoses which included but were not EX Order 26.4B1 Review of the entry Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 the resident had a Brief Interview of Mental Status of EX O meaning Resident #185 had EX Order 26.4B1 EX Order 26.4B1. Review of section J of the MDS, Health Conditions showed that the resident had a EX Order in the last month prior to admission to the facility. On 11/16/23 at 01:57 PM, the surveyor reviewed Resident #185 EX Order 26.4B1. The incidents revealed that on EX Order 26.4B1 the resident had a EX Orde and was EX Order 26.4B1 The resident was EX Order 26.4B1, and EX Order 26.4B1 Following the investigation, the resident was not able to verbalize the incident.	F 655	Residents affected by deficient practice: " The facility failed to ensure that a Baseline Care Plan was implemented within 48 hours on a resident who was at NJ Exec. Order 26:4.b.1. This deficient practice was observed with 1 resident (Resident #185) who was admitted on EX Order 26.4B1 and whose Baseline Care Plan was not implemented unti EX Order 26.4B1. Identify those individuals who could be affected by the deficient practice: " The EX Orde care plan for Resident #185 was initiated on EX Order 26.4B1 and interventions of NJ Exec. Order 26:4.b.1, frequent monitoring for 72 hours, EX Order 26.4B1 checks, and EX Order 26.4B1 therapy were put in place. " The affected resident #185 was observed for NJ Exec. Order 26:4.b.1 and monitored for any adverse effects related to the deficient practice with none noted. " All residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: " All facility nursing staff were re-educated on the facility□s policy for Implementation of Baseline Care plans. " All facility resident care plans were audited for completion.	

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F 655	Continued From page 8 On 11/17/23 at 09:00 AM, the surveyor reviewed Residents #185 Admission Nursing Comprehensive Assessment dated EX Order 26.4B1. Under the mobility section it indicated the resident was NJ Exec. Order 26:4.b.1 in the room or in the corridor. Under the section for EX Order 26.4B1 it revealed the resident had a EX Order in the last month prior to admission to the facility and the resident had sustained a EX Order 26.4B1 in the 6 months prior to admission to the facility. The score of the assessment indicated Resident #185 was EX Order 26.4B1 " EX Order 26.4B1. On 11/17/23 09:44 AM, the surveyor reviewed Resident #185 care plan which showed a focus of EX Order was initiated on NJ Exec. Order 26:4.b.1, following the EX Order at the facility. Prior to the resident EX Order 26.4B on EX Order 26.4B1 the resident did not have a EX Order care plan in place or EX Order prevention interventions. The EX Order care plan was initiated on EX Order 26.4B1 and interventions of NJ Exec. Order 26:4.b.1, frequent monitoring for 72 hours, EX Order 26.4B1, and EX Order 26.4B1 were put in place on NJ Exec. Order 26:4.b.1. On 11/17/23 at 11:23 AM, the surveyor met with the Director of Nursing (DON). The DON provided surveyor with the resident's care plan. The DON told the surveyor, "I'm going to be honest, the baseline care plan and regular care plan were completed on the 6th. The surveyor asked if it was in the time frame to complete a baseline care plan and the DON responded, "no". On 11/22/23 at 01:28 PM, the surveyor reviewed the care plan titled, Managing Falls and Fall Risks. The policy had a reviewed date of 01/2023. Under the section titled, "Resident Centered Approaches to Managing Falls and Fall Risk, number one indicated the staff, with the	F 655	Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/designee to conduct compliance audits of Base-line care-planning, ensuring completion by all departments within 48-hours of admission. " The duration of all audits will consist of completion one-time weekly x4 weeks then two times Monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 655	Continued From page 9 input of the attending physician will implement a resident centered fall prevention plan toreduce specific risk factors for falls for each resident at risk or with a history of falls. NJAC 8:39-11.2 (d)	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(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: Based on observation, interview, and review of pertinent facility documentation it was determined the facility failed to 1. Obtain physician orders to change EX Order 26.4B1 on a resident who was ordered EX Order 26.4B1 (a devices that delivers EX Order 26.4B1 EX Order 26.4B1 and 2. Obtain physician orders for care of a EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1) site for a resident. This was identified in 1 of 2 residents reviewed for NJ Exec. Order 26:4.b.1 (Resident #61) and 1 of 2 residents reviewed for EX Order 26.4B1 (Resident #31) and was identified by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. Nursing Board The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical	F 658	Residents affected by deficient practice: " The facility failed to a.) Obtain physician orders to change EX Order 26.4B1 EX Order 26.4B1 on a resident who was ordered a EX Order 26.4B1 and EX Order 26.4B1 and b.) obtain physician orders for care of a EX Order 26.4B1 EX Order 26.4B1 for a resident. This was observed for 1 of 2 residents (Resident #31) reviewed for EX Order 26.4B1 and for 1 of 2 residents (Resident #61) reviewed for EX Order 26.4 tubes. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by the deficient practice. " The affected residents # 31 and # 61 were monitored for any adverse effects of the deficient practices with none noted.	12/21/23

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F 658	Continued From page 10 and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 with in 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." 1.On 11/13/23 at 11:11 AM, during initial tour of the facility the surveyor observed Resident #31 in bed. Resident #31 was wearing EX Order 26.4B1 being delivered via EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 per minute. The EX Order 26.4B1 and EX Order 26.4B1 was dated EX Order 26.4B1 Review of Resident #31 admission record revealed the resident had medical diagnoses which included but were not limited to EX Order 26.4B1 EX Order 26.4B1 s. Review of the quarterly Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1 indicated the resident had EX Order 26.4B1 EX Order 26.4B1 and the Brief Interview of Mental Status could not be completed.	F 658	What corrective action will be accomplished for those residents affected by the deficient practice: " All facility nursing staff were re-educated on policies for Enteral Feeding Care and Oxygen/Oxygen Tubing. " All residents on Oxygen were audited for orders for Oxygen Tubing changes. " All residents on Enteral Feedings were audited for Enteral Tube Care orders. " An order was immediately obtained for Resident #31 for EX Order 26.4B1 changes. " An order for EX Order 26.4B1 Care was immediately obtained and rendered for Resident #61. Measures or systemic changes to ensure that the deficiencies will not recur: " DON/designee to conduct compliance audits for completeness of orders for residents on Oxygen and Enteral Feeding. " The duration of all audits will consist of completion one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 658	Continued From page 11 On 11/14/23 at 09:58 AM, the surveyor reviewed the physician orders which showed an order for EX Order 26.4B1 per minute for EX Order 26.4B1 EX Order 26.4B1 It was an active order dated EX Order 26.4B1 On 11/14/23 at 10:16 AM, the surveyor reviewed Resident # care plan which included a focus of EX Order 26.4B1 and EX Order 26.4B1 and one intervention was to apply EX Order 26.4B1 as prescribed by the doctor. On 11/14/23 at 10:27 AM, the surveyor reviewed the physician orders and could not locate an order to change EX Order 26.4B1 . On 11/16/23 at 10:10 AM, the surveyor observed the resident in bed, eyes closed EX Order 26.4B1 at EX Order 26.4B1 . The EX Order 26.4B1 and the EX Order 26.4B1 were dated EX Order 26.4B1 On 11/17/23 at 10:14 AM, the surveyor interviewed the subacute unit Registered Nurse (RN) regarding EX Order 26.4B1 changes. The RN told the surveyor the EX Order 26.4B1 was changed once per week. The surveyor asked who was responsible and how would we know it was changed and the RN stated, (it is hanged by whoever is on shift, and they sign it off on the Treatment Administration Record (TAR) or the Medication Administration Record (MAR)". The surveyor asked if there was a specific day they were changed on the unit and she told the surveyor the days are different based on when the resident was admitted to the facility. The surveyor then asked the RN to look on the MAR and TAR and show the surveyor where it was signed. The RN could not locate the tubing	F 658		

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F 658	Continued From page 12 changes on the MAR or TAR. On 11/17/23 at 1030 AM the surveyor interviewed unit LPN [EX Order 26.4B1]) who told the surveyor, "It should it be on the Mar or Tar, yes it should be and we will fix it". On 11/22/23 at 11:12 AM, the surveyor reviewed the policy titled, "Oxygen Administration" with an updated date of 10/2019. The purpose of the policy was to provide guidelines for safe oxygen administration. The policy did not include changing of nasal cannula tubing. 2. On 11/14/2023 at 12:34 PM, the surveyor observed Resident #61 lying in bed with his/her eyes closed. The surveyor observed that the head of the bed was elevate in an upright position and the resident was being administered [EX Order 26.4B1] [EX Order 26.4B1] formula via a [EX Order 26.4B1] through a [EX Order 26] inserted in the resident's [EX Order 26.4B1] A review of Resident Quarterly Minimum Data Set (an assessment tool) dated [EX Order 26.4B1], revealed that Resident #61 had a [EX Order 26.4B1] while a resident in the facility.	F 658		

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A review of Resident #61's November 2023 physician orders located in the electronic medical record (EMR) revealed an order for EX Order 26.4B1 (EX Order 26.4B1 to be administered at EX Ord EX Order 26.4B1 /hour with a total volume of EX Order mL's. There were no additional orders for the care of the EX Order 26.4B1 site.

On 11/16/2023 at 10:36 AM, the surveyor interviewed the resident's EX Order 26.4B1 aide and observed Resident #61 during morning care. The resident had an EX Order 26.4B1 binder in place and on request of the surveyor, the binder was removed to reveal the EX Order 26.4B1 tube site. The NJ Exec. Orde entrance site on the EX Order 26.4B1 did not have a NJ Exec. Order 26:4.b.1 . The EX Order 26.4B1 aid stated that the nurse takes care of the EX Order 26.4B1 site. Shortly later, the nurse came into the room and cleaned the EX Order 26.4B1 l site with EX Order 26.4B1 EX Order 26.4B and then placed a gauze pad at the EX Order 26 site. When the surveyor asked the nurse what the physician orders were for the EX Order 26.4B1 site, the nurse was unable to confirm, stating she wasn't sure, but she believed it was "protocol" to use EX Order 26 and place gauze at the EX Order 26.4B1 site.

Review of the Resident #61's November Care Plan (CP) indicated that the resident required EX Order 26.4B1 EX Order 26.4B1) that EX Order 26.4B1). The CP included nursing interventions to care of the NJ Exec. Order 26:4.b.1 that included: "Provide local care to EX Order 26.4B1 site as ordered. Report results to MD and follow up as indicated."

Review of the EX Order 26.4B1 Treatment Administration Record (TAR) as well as the Medication Administration Record (MAR), did not

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F 658	Continued From page 14 reveal documentation of the assessment, care, or treatment of the EX Order 26.4B1 site. During an interview with the Director of Nursing (DON), she acknowledged that a physician order for the care of the EX Order 26.4B1 site as well as documentation of the care, is required as per facility policy. Review of the facility's policy for enteral feeding, titled, "Enteral Feedings-Safety Precautions," with a review date of 1/2023, found under "Preventing Skin Breakdown," # 2: "Assess for leaking around the gastrostomy or jejunostomy frequently during the first 48 hours after tube insertion, and then with each feeding or medication administration." In addition, under #3: "Observe for signs of skin breakdown, infection and irritation;" and "Document all assessments, findings and interventions in the medical record." NJAC 8:39-27.1 (a)	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		12/21/23

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F 755	Continued From page 15 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records (MR) and other pertinent facility documentation, it was determined that the facility failed to administer medications in accordance with the medication's cautionary statement, and manufacturer specifications. This deficient practice was identified for 1 of 2 nurses who administered medications to 2 of 4 (Residents #27 and #98) observed during medication pass and was evidenced by the following: On 11/15/2023 at 08:18 AM, the surveyor observed Licensed Professional Nurse (LPN) #1 who prepared seven medications, which included [redacted]	F 755	Residents affected by deficient practice: " The facility failed to administer medications in accordance with the medications cautionary statement, and manufacturer specifications. This deficient practice was identified for 1 of 2 nurses who administered medications to 2 of 4 residents (Residents #27 and #98). Identify those individuals who could be affected by the deficient practice: " Residents #27 and #98 were monitored for any adverse effects of the deficient practice with none noted. " All residents have the potential to be affected by the deficient practice.	

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F 755	Continued From page 16 EX Order 26.4B1), for Resident #27. LPN #1 reviewed the EX Order 26.4B1 label that was on the bingo card (blister pack) in the presence of the surveyor and failed to acknowledge a pharmacy cautionary statement that specified, "Take with food..." prior to administration. On 11/15/23 at 8:31 AM, the surveyor observed LPN #1 who prepared nine medications, which included EX Order 26.4B1 give EX Order tablet EX Order 26.4B1 EX Orde times a day for EX Order 26.4B1 give EX Order tablet by EX Order 26.4B1 a day for EX Order 26 EX Order 26.4B1), for Resident #98. LPN #1 reviewed the EX Order 26.4B1 EX Order label and th EX Order 26.4B1 surveyor and failed to acknowledge a pharmacy cautionary statement that specified, "Take with food..." prior to administration. On 11/15/23 at 8:41 AM, the surveyor interviewed LPN #1 who stated that she did not note the cautionary labels which cautioned that both EX Order 26.4B1 and EX Order 26.4B1 were required to have been administered with food. LPN #1 stated she thought that breakfast would have been served by now. LPN #1 further stated that she could have given the resident's medications with an oral supplement or a snack, if the breakfast trays were not yet provided. LPN #1 then continued to prepare medications for the next resident without first providing Resident #27 and #98 with nourishment post-medication administration as she had described. On 11/16/2023 at 10:37 AM, the surveyor interviewed the Licensed Practical Nurse/Unit	F 755	What corrective action will be accomplished for those residents affected by the deficient practice: " All facility nursing staff were re-educated on the facility□s Medication Pass Policy. " Nurse LPN was immediately educated at the time of the deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/designee to complete medication pass monitoring audits with the nurses across all three shifts. " The duration of all audits will consist of completion two-times weekly x4 weeks and then three times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 755	Continued From page 17	F 755		

Manager (LPN/UM) who stated that it was standard practice for nursing to review the medication label for cautionary instructions which indicated that the medication was required to have been given with a meal. LPN/UM further stated that LPN #1 should have either waited for meal delivery or obtained something comparable to a meal from the pantry prior to medication administration.

On 11/17/2023 at 09:28 AM, the surveyor interviewed the Licensed Practical Nurse/Assistant Director of Nursing/ Educator (LPN/ADON/Ed) who stated that she told nursing to perform three checks prior to medication administration. She further stated that if a cautionary label indicated to give the medication with food then the resident's tray should be in front of the resident or the nurse should wait to give the medication until the meal arrived prior to medication administration. She stated that if a cautionary label was not observed, and the medication was not given with food, the resident could experience upset stomach or irritation of the lining of the stomach. The LPN/ADON/Ed further stated that EX Order 26.4B1 should be separated and given with food and a full glass of water to avoid stomach upset or nausea may result.

On 11/17/23 at 10:36 AM, the surveyor interviewed the Consultant Pharmacist (CP) via telephone. The CP stated that both EX Order 26.4B1 and EX Order 26.4B1 should be given with a meal. The CP explained that with EX Order 26.4B1 EX Order 26.4B1 there was a potential for EX Order 26.4B1. The CP further stated that she was not sure with EX Order 26.4B1 though the manufacturer specified to take it with food as a matter of timing.

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F 755	Continued From page 18 On 11/20/23 at 11:27 AM, the surveyor interviewed the Director of Nursing (DON) who stated that nursing was required to review and follow the cautionary statements as directed. The DON further stated that if the cautionary statement directed to give a medication with food, then the nurse should wait until the resident's meal tray arrived prior to medication administration. Review of the facility's policy titled, "Administering Medications," did not address medication cautionary instructions. NJAC 8:39-29.2(d)	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 812		12/21/23

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F 812	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. This deficient practice was evidenced by the following: On 11/13/23 from 09:25 AM until 10:35 AM the surveyor, who were accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1.A Food Service Worker (FSW) was observed with a hairnet on with the hair near her ears exposed. Another FSW was observed with a surgical mask on his face. His facial hair was exposed. The FSD stated that hairnets should cover all hair. He also stated that the FSW should be wearing a beard guard. 2. In the snack refrigerator there were five individual cartons of commercially prepared vanilla shakes with no use by date. The FSD stated the staff should place a use by date on them once they come out of the freezer. He furthered the shakes are not outdated but should have a used by date placed. 3. In the third refrigerator, there 2 hardboiled eggs 2 in a bin with no label and no date. The FSD stated the eggs should be dated. 4. In the third refrigerator there were individual cups of cream cheese in an opened box with a received date of 5/16. The FSD stated he will throw them out.	F 812	Residents affected by deficient practice: The facility failed to handle potentially hazardous foods and maintain sanitation in a safe consistent manner. An employee was observed with a hairnet on with the hair next to ear exposed. Another employee was observed with a surgical mask on his face and his facial hair exposed, with no beard guard. On 11/15/23 In the refrigerator, 5 individual, commercially prepared cartons of vanilla shakes with no use by dates were observed. These were taken from freezer and no use by date was placed on them. Two hardboiled eggs were found in a bin with no date and individual cups of cream cheese were in an opened box with received by date of 5/16/23. There were fresh tomatoes in an open box with a received date of 10/31/23 which are good for 10 days and a box of zucchini dated 10/17/23 which are good for 15 days. In the freezer, closed plastic shelves of turkey and vegetable burgers which were not labeled or dated were observed. Observed on the Unit 200 ice machine, a black substance on the plastic downspout. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by the deficient practice. " No adverse effects of the deficient practices were noted in any of the residents.	

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F 812	Continued From page 20 5. In the third refrigerator, there were fresh tomatoes in an opened box dated 10/31. The FSD stated the tomatoes are good for 10 days. There was a box of zucchini dated 10/17. The FSD stated they are good for 15 days. He said he will throw them out. 6. In the freezer, there were closed plastic sleeves of turkey burgers and vegetable burgers with no label and no date. The FSD stated his staff took them out of the box. He stated they should be labeled and dated. On 11/15/23 at 09:57 AM, the surveyor observed the Unit 200 ice machine with the Unit 200 Nurse Manager (NM). A black substance was observed on the plastic downspout. The NM is not sure who takes care of cleaning the machine but will get back to this surveyor. On 11/15/23 at 11:08 AM, the Licensed Nursing Home Administrator (LNHA) stated that the ice machine is cleaned quarterly. He stated that it is due at the end of this month. On 11/15/23 at 12:04 PM, the LNHA stated that he observed the Unit 200 ice machine and it needs to be cleaned. He stated that it will be cleaned tonight. The surveyor reviewed the 6/15/18 personal hygiene policy provided by the facility Administrator. The policy reflected 7. Hair restraints such as hats, hair coverings, or nets are worn to effectively keep hair from contacting exposed food. Facial hair coverings are used to cover all facial hair.	F 812	What corrective action will be accomplished for those residents affected by the deficient practice: " Employee removed surgical mask immediately and placed a beard guard on. The other employee observed immediately tucking their hair under their hairnet. " All dietary staff were re-educated on proper use of hairnets and wearing of beard guards. " The Individual cream cheese cups with received date of 5/31/23, the fresh tomatoes in an open box dated 10/31/23 and the fresh zucchini dated 10/17/23 were all immediately discarded. " All items in the refrigerator storeroom and freezer were inspected for expiration dates. " All dietary staff were in-serviced and instructed on all items must have an opened-date and us- by date. All items must be labeled before going into the refrigerator storeroom or freezer and any expired items must be discarded. " All nursing unit ice machine downspouts were immediately inspected and cleaned. " Maintenance staff were in-serviced on proper deep cleaning of ice machine downspouts. Measures or systemic changes to ensure that the deficiencies will not recur:	

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F 812	Continued From page 21 The surveyor reviewed a 6/15/18 Refrigerated/Frozen Storage policy provided by the LNHA. The policy reflected 1.4 All foods are labeled with name of product and the date received and "use by" date once opened. Manufacturer "use by" dates are used until opened. 1.5 Prepared foods are labeled and dated with the name of product, date opened, and "use by" date. 1.9 Frozen, commercially prepared shakes are thawed under refrigeration; the date removed from the freezer is marked on the case. 1.9.2 Individual shakes are labeled with "use by" date when removed from the original container. The surveyor reviewed the Food Storage and Retention Guide provided by the LNHA. The policy reflected that cream cheese can be stored for two weeks. It reflected that fresh fruit and vegetables can be stored for one week or until visual decline is noted. The surveyor reviewed the Work History Report provided by the LNHA. It reflected that preventative maintenance was completed on the ice machines on 8/31/23.	F 812	" Dietary Manager/designee will audit proper use of hair nets and beard guards will be conducted daily x4 weeks and then continued weekly x2 months. " Dietary Manager/designee will audit Labeling and Dating of food daily x4 weeks and 1x weekly x2 months. " Dietary Manager/designee will visually inspect fresh produce daily for x4 weeks and then 1x weekly x2. " Maintenance Director/designee will audit all nursing unit ice machine downspouts for cleanliness weekly x4 weeks and monthly x2 months. " Results of audit will be reported to the Administrator and reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. .	
F 880 SS=E	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		12/21/23

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	315330	A. BUILDING _____ B. WING _____	C 11/21/2023

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F 880	Continued From page 22 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 23 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility records, it was determined that the facility failed to a.) ensure infection control practices were adhered to in a manner that would decrease the possibility of the spread of infection during EX Order 26.4B1 care, and b.) medication administration. This deficient practice was observed with 1 of 2 residents (Resident# 5) reviewed for EX Order 26.4B1, and for 1 of 2 nurses observed during the medication observation pass on 1 of 3 nursing units, (EX Order 26.4B1 Floor). This deficient practice was evidenced by the following: a.) On 11/13/23 at 10:32 AM, during initial tour of	F 880	Residents affected by deficient practice: " The facility failed to a.) ensure infection control practices were adhered to in a manner that would decrease the possibility of the spread of infection during EX Order 26.4B1 care, and b.) medication administration. This deficient practice was observed with 1 of 2 residents (Resident #5) reviewed from EX Order 26.4B1 EX Order 26.4B1 and for 1 of 2 nurses observed during the medication observation pass on 1 of 3 nursing units, (EX Order 26.4B1 Floor). Identify those individuals who could be affected by the deficient practice:	

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F 880	Continued From page 24 the facility, the surveyor observed Resident #5 resting in bed in their room. On the wall outside of the resident's room door was an "Enhanced Barrier Precaution" sign and a plastic bin with three drawers containing disposable gloves and disposable gowns. The Clinical Supervisor (CS) informed the surveyor that this resident was on transmission-based precautions due to having a EX Order 26.4B1. Review of Resident #5's Admission Record indicated the resident was admitted to the facility with diagnosis which included but not limited to EX Order 26.4B1 Review of Resident #5's quarterly Minimum Data Set (MDS) (a comprehensive assessment tool) dated EX Order 26.4B1, indicated the resident had a brief interview of mental status (BIMS) score of EX Ord out of 15 indicating EX Order 26.4B1 was at risk for developing EX Order 26.4B1, had a EX Order 26.4B1 EX Order 26.4B1 which was being treated with NJ Exec. Order 26:4.b.1 and application of NJ Exec. Order 26:4.b.1. Review of the resident's care plan indicated an active care focus area with an initiation date of EX Order 26.4B1 for potential and actual impairment to EX Order 26.4B1 with a goal to have no complications related to EX Order 26.4B1) EX Order 26.4B and will display improvement or will be healed through the review date. This care focus had intervention planning which included but was not limited to, follow facility protocols for treatment of NJ Exec. Order 26	F 880	" All residents have the potential to be affected by the deficient practice. " Resident #5 was monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " All facility nursing staff re-educated on policy Handwashing/Hand Hygiene and competencies completed on Hand Hygiene procedure. " Nurse LPN/WC and LPN#2 immediately educated at the time of deficient practice. " All other facility staff re-educated in the Handwashing/Hand Hygiene policy. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/designee to conduct compliance audits on handwashing across all departments. " The duration of all audits will consist of completion of all staff, one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 880	Continued From page 25 Review of the resident's physician's orders and the "Order Summary Report" included the following orders: EX Order 26.4B1 [redacted] EX Order 26.4B1 Review of the EX Order 26.4B1 treatment administration record (TAR) revealed this EX Order 26.4B1 care treatment was completed as ordered daily. On 11/17/23 at 9:23 AM, the surveyor observed the Licensed Practical Nurse/EX Order 26.4B1 Care Nurse (LPN/WC) perform the ordered EX Order 26.4B1 care treatment. The following was observed: After bringing the EX Order 26.4B1 treatment cart to the resident's doorway, (keeping it in the hallway outside the room door), washing her hands, and gathering all the required materials and medications to be used, donning (putting on) a disposable gown and gloves, the LPN/WC brought the mediations and dressings, which she had gathered on a clean barrier pad, brough the pad with the supplies into the room and placed it on the resident's tray table, then proceeded with the EX Order 26.4B1 care. The LPN/WC first doffed (removed) the gloves she was wearing while preparing the working area and the trash bag, without performing hand hygiene, donned new gloves. With the assistance of another nurse, they turned the resident onto their EX Order 26.4B1	F 880		

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F 880	Continued From page 26 removed the old EX Order 26.4B1 dressing, disposed of it into the trash bag, doffed and disposed gloves, did not perform hand hygiene, donned new gloves, patted the EX Order 26.4B1 soaked gauze, disposed of the gauze, doffed gloves, no hand hygiene, donned new gloves, patted the EX Order 26.4B1 with more acetic acid gauze, disposed of the gauze, doffed gloves, no hand hygiene, donned new gloves, used clean dry gauze to pat the cleaned EX Order 26.4B1 dry, disposed of that gauze, doffed gloves, no hand hygiene, donned new gloves, repeated pat dry with new clean gauze, doffed gloves, no hand hygiene, donned new gloves, went to the glove box hanging on the wall by the room door, obtained a handful of more clean gloves, placed them on the barrier pad, doffed gloves, no hand hygiene, donned new gloves, using a clean application stick she applied the NJ Exec. Order 26:4.b.1 to the resident's NJ Exec. Order 26:4.b.1 surrounding the EX Order 26.4B1 disposed of medication cup and stick, doffed gloves, no hand hygiene, donned new gloves, applied the NJ Exec. Order 26:4.b.1 to the EX Order 26.4B1, doffed gloves, no hand hygiene, donned new gloves, applied the large foam dressing to the EX Order 26.4B1 replaced the resident's NJ Exec. Order 26:4.b.1, repositioned the resident onto their back, doffed gloves, no hand hygiene, donned new gloves, disposed of all remaining supplies and barrier pad into trash bag, disposed the trash bag into a trash bin, doffed the gown, used hand sanitizer to perform hand hygiene, then proceeded to the bathroom to wash her hands. On 11/17/23 at 9:49 AM, once the LPN/WC returned to the treatment cart, the surveyor interviewed her. The LPN/WC informed the surveyor that she is the facility's EX Order 26.4B1 care	F 880		

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F 880	Continued From page 27 nurse and is usually the one performing [EX Order 26.4B1] care for residents requiring it. The LPN/WC informed the surveyor that she had "reviewed the regs" prior to this observed treatment and that "just glove changes" are required during care and there is "no more sanitizer (hand hygiene) in between glove changes." The LPN/WC acknowledged she did not perform any hand hygiene in between glove changes during the process of [EX Order 26.4B] care, and stated, "there's supposed to be hand sanitizing, I apologize." At 10:25 AM, the LPN/WC provided the surveyor with the facility policy regarding [EX Order 26.4B1] care and stated, "I should have been doing hand hygiene in between glove changes." On 11/17/23 at 10:50 AM, the surveyor interviewed the Infection Preventionist Registered Nurse (IP), who stated, "regardless of what you're doing, if there is glove change, there should be hand hygiene in between glove changes." b.) On 11/15/23 from 08:48 AM to 9:12 AM, the surveyor observed Licensed Practical Nurse (LPN) #2 as she prepared medications for administration to two residents (an unsampled Resident and Resident #49) during the Medication Pass: On 11/15/23 at 8:50 AM, the surveyor observed LPN#2 as she came out of an unsampled resident's room with an Insulin pen in her gloved hands. LPN #2 then proceeded to reach into her uniform pocket, obtained keys and unlocked the medication cart. LPN #2 then opened the top drawer of the medication cart and proceeded to	F 880		

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F 880	Continued From page 28 return the insulin pen to a plastic bag and closed the drawer. LPN #2 then doffed (removed) her gloves and did not perform hand hygiene before she responded to a resident's call light and reportedly assisted the resident to open their milk carton. The surveyor did not observe LPN #2 perform hand hygiene as she exited the resident's room with alcohol based hand rub (ABHR) that was present at the entrance of the room before she prepared and administered medications to an unsampled resident. On 11/15/23 at 8:58 AM, the surveyor observed LPN#2 who opened a new bottle of [EX Order 26.4B1] (supplement) and removed the protective foil with her bare hands before she poured the medication into a medication cup and and prepared additional medications which were then administered to Resident #49. On 11/15/23 at 8:57 AM, the surveyor observed LPN #2 perform hang hygiene with ABHR before she prepared medications for Resident #100. LPN #2 then proceeded to enter the supply room and touched the exterior of the door with her right hand. LPN #2 then returned to the medication cart and opened a new bottle of [NJ Exec. Order 26:4.b.1] [redacted] and removed the protective foil with her bare hands before she poured the medication into a medication cup and prepared additional medications which were then administered to the resident. LPN #2 handed the resident a cup of water upon request then proceeded to touch the back of the resident's shirt when the resident complained that the tag inside the shirt needed to be cut as it reportedly caused the resident to complain of itching. LPN #2 then left the resident's room and failed to perform hand hygiene before she accessed the	F 880		

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F 880	Continued From page 29 computer on top of the medication cart and charted the resident's medications. On 11/15/23 at 9:12 AM, the surveyor interviewed LPN #2 who stated that she was supposed to perform hand hygiene when she doffed her gloves after EX Order 26.4B1 for infection control reasons . LPN #2 stated that when she answered the resident's call bell and opened the resident's milk carton immediately after EX Order 26.4B1 administration it was also an infection control issue. LPN #2 stated that when she touched Resident #100's cup and back she should have performed hand hygiene prior to accessing both the computer and medication cart as failure to do so, "could result in the spread of germs." On 11/16/23 at 10:37 AM, the surveyor interviewed the Licensed Practical nurse/Unit Manager (LPN/UM) who stated that staff must wash their hands when they doffed their gloves before they moved onto any other task for infection control purposes. The LPN/UM added that if the nurse administered medications and touched a resident without washing their hands afterward, they could spread germs. On 11/17/23 at 09:47 AM, the Infection Preventionist/Registered Nurse (IP/RN) stated that nursing could potentially contaminate all of the surfaces touched if hand hygiene was not performed. The IP/RN stated that hand hygiene should be performed when gloves were doffed to prevent the spread of infection. On 11/20/23 at 11:27 AM, the surveyor interviewed the Director of Nursing (DON) who stated that hand hygiene should be performed after gloves were doffed to avoid	F 880		

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F 880	Continued From page 30	F 880		

cross-contamination. The DON stated that contamination was possible if you did not wash your hands after you have doffed your gloves and accessed the medication cart. The DON stated that nursing should perform hand hygiene before opening a new bottle of medications and pouring them. The DON further stated that hand hygiene should be performed after touching a resident to prevent contamination.

On 11/20/23 at 12:20 PM, the DON and the Administrator were made aware of the surveyor's concerns related to Medication Administration.

The LPN/ADON/Educator provided the surveyor with an in-service sign-in sheet which indicated that LPN #2 received education on COVID-Handwashing/PPE (personal protective equipment, equipment worn to protect the body from harm or disease) on 11/16/23.

Review of the facility's "Handwashing/Hand Hygiene" policy Reviewed 1/2023, revealed the following:

Policy Statement:
This facility considers hand hygiene the primary means to prevent the spread of infections.

"use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...before and after direct contact with residents ... before handling clean or soiled dressings, gauze pads, etc, ... before moving from contaminated body site to a clean body site during resident care, ... after contact with a resident's skin, after contact with blood or body fluids, after handling used dressings,

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F 880	Continued From page 31 contaminated equipment, etc ... after removing gloves ...before and after assisting a resident with meals; The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." Review of the facility's "Wound Care" policy with a review date of 1/2023 included: " ...put on clean gloves. Loosen tape and remove dressing. Pull glove over dressing and discard into appropriate receptacle. Perform hand hygiene. Put on gloves ..." NJAC 8:39-19.4(a)(b)(c)(d); 27.1(a)	F 880		

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S 000	Initial Comments NJ Complaint # NJ00163758, NJ00163736, NJ00166680, NJ00163063 The facility is 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		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ Complaint # NJ00163758, NJ00163736, NJ00166680, NJ00165288 Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the dates below as mandated by the State of New Jersey and was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	Residents affected by deficient practice: The facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. All residents monitored for any adverse	12/21/23

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

Electronically Signed | 12/08/23

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1.Week of Complaint staffing from 03/05/2023 to 03/11/2023, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -03/05/23 had 10 CNAs for 127 residents on the day shift, required at least 16 CNAs. -03/06/23 had 9 CNAs for 127 residents on the day shift, required at least 16 CNAs. -03/07/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/08/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -03/10/23 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -03/11/23 had 11 CNAs for 121 residents on the	S 560	effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. " The facility will take the following measures to ensure this deficient practice does not occur.The facility will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to audit the effectiveness of hiring strategies to	

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 _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	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 560	Continued From page 2 day shift, required at least 15 CNAs. 2. Week of Complaint staffing from 04/23/2023 to 04/29/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -04/23/23 had 10 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/24/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -04/25/23 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -04/26/23 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. -04/27/23 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs. -04/28/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -04/29/23 had 11 CNAs for 120 residents on the day shift, required at least 15 CNAs. -04/29/23 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. 3. Weeks of complaint staffing 05/21/23 to 06/03/23 the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 2 of 14 evening shifts as follows: -05/21/23 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. -05/22/23 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs. -05/23/23 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -05/24/23 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs.	S 560	include open CNA and Licensed Nurse positions vs. new hires, reporting on successful strategies-to-hire based on percentages, and turnover rates. " The duration of all audits will consist of completion one-time weekly x 4 weeks then three times monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

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S 560	Continued From page 3 -05/25/23 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -05/26/23 had 12 CNAs for 125 residents on the day shift, required at least 16 CNAs. -05/27/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -05/27/23 had 10 CNAs to 22 total staff on the evening shift, required at least 11 CNAs. -05/28/23 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -05/28/23 had 9 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. -05/29/23 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -05/30/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs -05/31/23 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -06/01/23 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -06/02/23 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -06/03/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. 4.For the 2 weeks of staffing prior to survey from 10/29/2023 to 11/11/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/29/23 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -10/30/23 had 13 CNAs for 139 residents on the day shift, required at least 17 CNAs. -10/31/23 had 14 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/01/23 had 16 CNAs for 139 residents on the day shift, required at least 17 CNAs. -11/02/23 had 14 CNAs for 143 residents on the	S 560		

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 _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	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 560	Continued From page 4 day shift, required at least 18 CNAs. -11/03/23 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/04/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/05/23 had 12 CNAs for 143 residents on the day shift, required at least 18 CNAs. -11/06/23 had 13 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/07/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/08/23 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/09/23 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -11/10/23 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs. -11/11/23 had 11 CNAs for 141 residents on the day shift, required at least 18 CNAs. On 11/21/23 at 09:11 AM, the surveyor interviewed the facility Staffing Coordinator (SC) regarding staffing. NJ Exec. Order 26:4.b.1, staffing coordinator since NJ Exec. Order. The SC was able to verbalize the regulation and told the surveyor she makes phone calls to others if the numbers are not meeting the regulations and staff would come in to work for bonuses. The surveyor asked the SC if she felt the facility had the adequate staffing and she responded, "for the most part". On 11/21/23 at 10:50 AM, the surveyor spoke with the Director of Nursing (DON) regarding staffing. The DON stated the facility is generally "fully staffed, but there are a lot of call outs". The DON stated bonuses for retention and "other deals" were offered to the staff. On 11/22/23 at 10:14 AM, the surveyor reviewed	S 560		

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 _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

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S 560	Continued From page 5 the policy titled, "Staffing", with a reviewed date of 07/12/23. The policy statement indicated that the facility provides enough staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the Facility Assessment.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315330	A. Building B. Wing	1/3/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0655 Reg. # 483.21(a)(1)-(3) LSC	Correction Completed 12/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060315	A. Building B. Wing	1/3/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315330	A. BUILDING **01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	**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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 11/15/2023. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/15/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Marcella is a two-story building that was built in 1994. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 100 % of the building as per the Maintenance Director. The current occupied beds are 138 of 148.	K 000		
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above	K 362		12/21/23

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

Electronically Signed | 12/22/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315330	A. BUILDING **01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	**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
K 362	Continued From page 1 the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) 8.5.2.2. This deficient practice had the potential to affect all 138 residents who resided at the facility. Findings include: Observation on 11/15/23 at 12:56 PM of the smoke barrier located in the electrical room above the smoke barrier doors revealed a two-inch by one-inch hole, with two low voltage wires going through it which penetrated the smoke barrier and the one- and one-half inch sprinkler pipe passing through the wall. Continued observation revealed the smoke barrier was not protected by a system or material capable of restricting the transfer of smoke. During an interview at the time of the observation, the Maintenance Director and the Regional Maintenance Director both confirmed the	K 362	1. The penetration in the Smoke Barrier located in the Elevator Control Room was repaired with fire retardant caulk on November 20, 2023 2. All residents are considered at risk due to penetration in smoke compartment barriers. 3. The Maintenance Director or designee will follow behind all work done in the Facility that has the possibility of penetration of Smoke Barriers to ensure no penetrations exist or are repaired immediately if they are found. 4. The Director of Maintenance or designee will report to the Administrator on the status of all work done in the Facility that may have created new penetrations in any Smoke Barrier at Quarterly QA Meeting x 3.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315330	A. BUILDING **01** B. WING _____	**11/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 362	Continued From page 2 penetration in the smoke barrier was not protected by a system or material capable of restricting the transfer of smoke. NJAC 8:39-31.2(e)	K 362		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315330 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MARCELLA, LLC	2305 RANCOCAS ROAD BURLINGTON, NJ 08016

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0362	Correction Completed 12/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			