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 09/20/2019

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) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT # NJ 115284 CENSUS : 143 SAMPLE SIZE : 5	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment	F 580		11/17/19

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

Electronically Signed | 10/23/2019

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 09/20/2019

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) COMPLETION DATE
F 580	Continued From page 1 as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 115284 Based on interviews, review of the Medical Record (MR), and other pertinent facility documentation on 9/20/2019, it was determined that the facility staff failed to notify a resident's #1 contact of a change in condition ([redacted]), as well as follow their own facility policy titled "Accidents/Incidents", and "Change in Condition: Notification of " for 1 of 5 sampled residents (Resident #3). This deficient practice is evidenced by the following: 1. According to the facility Admission Record, Resident #3 was admitted to the facility on [redacted], with diagnoses which included but were not limited to : [redacted], and	F 580	1. It was noted that the center notified Emergency Contact #2 regarding Resident #3's fall on [redacted] and not the Emergency Contact #1 ([redacted]). 2. All residents who reside at the center have the potential to be affected. Nursing staff were in-serviced on Notify of Change in Condition policy and documentation of all attempts to reach Power of Attorney and/or Primary Contact to inform of changes. 3. The Unit Managers will review all Incidents and Accidents reports for their designated units weekly for 4 weeks then monthly for 4 months to ensure Power of Attorneys and/or Primary Contacts were	

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 09/20/2019

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) COMPLETION DATE
F 580	Continued From page 2 [redacted].	F 580	notified of the changes. The Director of Nursing and/or Assistant Director of Nursing will complete random monthly audits to ensure notification to the Power of Attorney and/or Primary Contact has been documented appropriately in nursing notes for 4 months.	

According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating that Resident #3 had severely impaired cognition. The MDS documentation included that Resident #3 required assistance for Activities of Daily Living (ADLs).

Review of a Care Plan (CP) dated [redacted],with a revision date of [redacted] under "Focus" revealed Resident is at risk for falls: [redacted] loss, lack of safety awareness, "Goal" : Resident will have no [redacted] with injury x 90 days. Interventions included but were not limited to: Assess for changes in medical status, [redacted] status, mental status and report to MD (Medical Doctor) as indicated. Remind and encourage to use call light for assistance.

Review of a "Change in Condition Evaluation" form dated [redacted]8, revealed that Resident #3 had a[redacted] on [redacted] "Found Resident in the bathroom sitting on the floor next to a empty ice cream cup and spoon."

Under "Name of family/healthcare agent notification," it was noted that the Emergency Contact #2 had been notified of the fall at 14:15 (2:15 p.m.) and not the Emergency Contact #1 [redacted].

Review of Progress Notes dated [redacted] at 12:30, revealed "A change in condition has been noted. The symptoms include: [redacted], in the afternoon. Name of family/Healthcare agent notified: Emergency Contact #2."

4. The results of the monthly audit will be reported to the Director of Nursing and/or Assistant Director of Nursing monthly, who will audit and monitor for trending and compliance. The results of the audits will be reported by the Director of Nursing and/or Assistant Director of Nursing at the monthly QAPI meetings for 6 months then quarterly there on after. Additional actions will be taken as appropriate.

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 09/20/2019

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) COMPLETION DATE
F 580	Continued From page 3 During an interview on 9/20/2019 at 11:20 a.m., the Licensed Practical Nurse Unit Manager (LPNUM) stated that when a resident sustains a fall the family is notified immediately, as soon as possible notifying the Doctor (DR) first then the emergent contacts. The LPNUM further stated call the first contact, run all contacts until I get someone. During an interview on 9/20/2019 at 11:43 a.m., the Assistant Director of Nursing (ADON) stated that Once the patient is assessed notify the Dr, then notify family immediately. The ADON further stated the POA is the first contact you call. Review of a facility policy titled "Accidents/Incidents" with a review date of 5/2/2018, under 2. Assessment, Medical Assistance, Documentation: under 2.1.5 revealed "The patients responsible party/family will be notified of the accident/Incident and any follow -up treatment needed." Review of a facility policy titled "Change in Condition: Notification of " effective date 11/28/2016, revealed under Policy: " A center must immediately inform the patient, consult with the patients physician, and notify, consistent with his/her authority, the patient's Health Care Decision Maker (HCDM), where there is: An accident involving the patient which results in injury and has the potential for requiring physician intervention..." NJAC 8:39 -13.1 (c)	F 580		

New Jersey Department of Health

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 09/20/2019

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
H5750	8:43E-13.4(b) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ : 115284 Based on review of the Medical Record (MR), as well as other pertinent facility documentation on 9/20/2019, it was determined that the facility failed to properly complete all sections of the Universal Transfer Form (UTF) as well as follow their own facility policy titled "Universal Transfer Form." 1. According to the "Admission Record", Resident #3 was admitted to the facility on [redacted], with diagnoses including but not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident # 3 had a Brief Interview for Mental Status score of [redacted], indicating that Resident #3 had [redacted] cognitive impairment. The MDS documentation included that Resident #3 required staff assistance for Activities of Daily Living (ADLs). Review of a Progress Note (PN) dated [redacted] at 16:52 (4:52 p.m.) revealed that Resident #3	H5750	1. It was noted Resident #3's Universal Transfer Form (UTF), dated [redacted], was not filled out in its entirety. 2. All residents who reside at the center have the potential to be affected. Nursing staff were in-serviced on Universal Transfer Form policy. 3. The Unit Managers will review all resident transfers to another healthcare facility for 4 months to ensure Universal Transfer Form was completed in its entirety and a copy has been maintained in the resident's chart. The Director of Nursing and/or Assistant Director of Nursing will check 5 resident charts to ensure the UTF is being completed and a copy is maintained in the resident's chart quarterly. 4. The results of the monthly audit will be reported to the Director of Nursing and/or Assistant Director of Nursing monthly, who will audit and monitor for trending and compliance. The results of the audits will be reported by the Director of Nursing and/or Assistant Director of Nursing at the	11/17/19

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

Electronically Signed | 10/23/19

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 09/20/2019

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
H5750	Continued From page 1 was sent to the hospital when 911 was called. Review of Resident #3's Universal Transfer Form (UTF) dated [redacted] revealed that the form was not filled out in its entirety, including Code Status, and items #8 Reason for Transfer, and items #10 thru #12 were left blank, items #14 thru #23, as well as item # 25 thru #29 were left blank. Review of the facility UTF policy dated [redacted] revealed under Process : 3. A completed paper copy of the UTF will be sent with the patient at the time of transfer.	H5750	monthly QAPI meetings for 6 months then quarterly there on after. Additional actions will be taken as appropriate.	