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	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Marcella	2305 Rancocas Road Burlington, NJ 08016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #3001244 Based on interviews, review of medical records, and review of other pertinent facility documents on 5/6/26, 5/7/26 and 5/12/2026, it was determined that the facility failed to maintain a safe environment and to provide adequate supervision for a resident (Resident #2) who was assessed to have poor safety awareness, impaired cognition, and was identified as an elopement and fall risk. Resident #2 was also identified having a history of fall and required supervision with ambulation (walking).The deficient practice was identified for 1 of 4 residents (Resident #2) reviewed and was evidenced by the following: The facility policy titled: Fall Prevention Program, with a revised date of 10/7/25, revealed that residents would receive individualized care that would minimize their risk of falls, and that interventions will be monitored for effectiveness.The facility policy titled: Elopements and Wandering Residents, dated 9/1/24, revealed that residents at risk for elopements would be provided with adequate supervision to prevent accidents.1.) Resident #2 was not at the facility at the time of the survey. A closed record review was conducted as follows:According to the admission Record, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: congestive heart failure, muscle weakness, schizophrenia, and difficulty in walking.According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 1/14/26, Resident #2 had a BIMs score of 11 out of 15, which indicated that the resident's cognition was moderately impaired. The MDS further revealed that the resident required assistance with all aspects of their activities of daily living (ADL), including supervision or touching assistance when walking.A review of Resident #2's Elopement Assessment - V 2, dated 3/23/26 at 4:08 PM, revealed that the resident scored 11 on the assessment which indicated high risk for elopement, and that Resident #2 had history of elopement attempt. The assessment further revealed that the resident had expressed a desire to leave, wandered, hovered at exits and that the resident had been observed standing near the elevator and was redirected by staff.A review of Resident #2's Care Plan (CP) revealed the following:- Resident is an elopement risk/wanderer, [related to] Impaired safety awareness, initiated 3/22/26. Interventions included the placement of a Wander Guard on the resident on 3/26/26, and to distract the resident from wandering by providing diversions, and to identify pattern of wandering.-Resident is a diuretic therapy initiated 1/8/26. Interventions included that staff monitor postural hypotension, dizziness and to encourage the resident to get up slowly and to sit before standing. Resident has increase risk for falls. -Resident used antidepressant and was to be monitored for adverse reactions which included falls and dizziness, initiated 1/8/26.--Activities of Daily Living (ADL) deficit, revised 1/23/26, which revealed that the resident required assistance with all aspects of their ADLs.A review of the secure care (Wander Guard's) section seven standard features and mode of operation of the manufacturer's instruction stated that the system allows free access of the door by staff members and visitors but quickly locks the door when a monitored, wandering resident approaches the door. The instruction stated that the code was used to reset an alarm or to escort a monitored resident through a door without creating an alarm .and that the code should only be given to authorized staff members.A review of Resident #2's Progress Notes (PN) revealed a nursing note dated 3/22/26 at 3:41 PM, created by Licensed Practical Nurse (LPN) #1. The (continued on next page)

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

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The nursing noted also indicated that Resident #2 was sent to the hospital for further evaluation due to unwitnessed fall with head impact; and due to increased risk of bleeding due to being on anticoagulant therapy.A review of Resident #2's Order Summary Report revealed the resident had an active physician's order initiated on 3/23/26 for WG due to the resident's poor safety awareness.A review of Resident #2's Treatment Administration Record (TAR) for April 2026 revealed that a WG was placed on the resident due to poor safety awareness and it was to be checked for placement on every shift. The treatment was signed as completed on 4/7/26 by LPN #2.A review of the facility's document titled: Fall, dated 4/7/26 at 6:20 PM, revealed that Resident #2 was, .observed seated on courtyard bench with visible abrasions to right facial check, lip and chin. The fall document further stated that Resident #2 reported feeling dizzy and fell forward onto [their] face. The Fall document further stated that Resident #2 received first aid treatment, neurological checks initiated, and that the resident was sent out to the hospital for further evaluation due to fall with facial injuries and for being on anticoagulant medications. A witness statement written by the Licensed Nursing Home Administrator (LNHA) dated 4/7/26, stated that LNHA saw Resident #2 when the resident came out of the elevator on the first floor alone on 4/7/26; and that the LNHA allowed the resident access into the Courtyard. The facility did not provide evidence that Resident #2, who had poor safety awareness, was supervised while they were in the courtyard.A staff witness statement dated 4/8/26, revealed that while a Dietary Aide (DA) was walking past the area where Resident #2 had fallen, she heard the resident yelling for help. The DA stated that she went to the scene and found Resident #2 on the ground with bloody face and that she stayed with the resident till a nurse arrived.According to a staff statement from the nurse (Licensed Practical Nurse #2) dated 4/7/26, she heard someone yelling for help and stating that a resident fell. LPN #2 stated that she then went to the courtyard and found Resident #2 in the courtyard and observed blood on the resident's right cheek and lip, and that a doctor came into the courtyard and evaluated the resident. 2.) The surveyor reviewed the medical record of Resident #3, and according to the admission Record, Resident #3 was admitted to the facility with diagnoses which included but were not limited to: cerebral infarction (stroke due to blocked blood vessel in the brain), type 2 diabetes, anxiety disorder, and hypertension.According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 2/11/26, Resident #3 had a BIMs score of 15 out of 15, which indicated that the resident's cognition was intact.An interview was conducted on 5/6/26 at 11:40 AM with Resident #3, who stated that at the first of each month, staff provided them with the elevator code. When asked who provided the code them, the resident stated: I have connections, and did not elaborate any further. The resident confirmed going downstairs regularly to smoke. The resident also stated that there were times when other residents wandered near the elevator which usually activated the elevator alarm. The resident stated that if staff were not around to turn off the alarm, it would keep ringing and that they had entered the code to turn off the alarm when it would be ringing and staff were not available.An interview was conducted on 5/6/26 at 10:18 AM with the Licensed Practical Nurse Unit Manager (LPN/UM), who stated that the facility had no locked units, but that the second-floor unit had a WG alarm system for the elevators. She stated that some of their residents were cognitively impaired and wandered on the unit and needed additional supervision to ensure their safety. LPN/UM explained that the wandering residents were provided with WG, and they were not to leave the unit without staff. As the surveyor and the LPN/UM toured the second-floor unit, LPN/UM showed the surveyor alarm panels located on both (continued on next page)

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LPN/UM further stated that Resident #3 no longer resided on the second-floor unit because of an incident that occurred when Resident #3, took another resident with a WG onto the elevator, and to the first floor after entering the elevator keypad code that bypassed the WG alarm system. When asked about who provided the keypad code to the resident, LPN/UM stated that she was not sure who provided the code to the resident. When asked how they determined which resident should be given the code, she stated she was not the one that provided residents with the code, but she knows that the resident must be alert and oriented to have the code.An interview was conducted on 5/6/26 at 12:52 PM with LPN #1, who stated that Resident #2 was observed to have exit seeking behavior and had poor safety awareness and wore a WG. She further stated that any resident wearing a WG that wanted to leave the unit would need to be escorted by staff to ensure their safety.During a follow-up interview on 5/6/26 at 1:25 PM, LPN/UM stated that she was aware that Resident #2 was an elopement risk and had a WG in place. LPN/UM stated that Resident #2 should not have been able to get off the unit without an escort. She stated that there were residents, including Resident #3, who were alert and oriented and had access to the elevator door code, but she was unsure who provided the resident with the code and that the codes were changed monthly. She further stated that she had not observed Resident #3 enter the code to bypass the alarm, but she was aware that the resident had the code and could deactivate the alarm if they entered the code.An interview was conducted on 5/6/26 at 2:57 PM with the Maintenance Director (MD), who stated that his staff was responsible for checking the WG door alarm system for functionality weekly. The MD stated that the alarm system was in place to keep residents safe by alerting staff if a resident attempted to leave the facility. He further stated that the code was updated monthly, and that a week prior to the change of code, he would provide all department heads with the new code during their morning meeting. He stated that no resident should ever have the code and that if he was told that a resident had the code, he would immediately change it.A joint interview was conducted with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) on 5/6/26 at 2:22 PM. During the interview the DON stated that the purpose of the WG system was to keep residents safe by ensuring that residents who were identified to be at risk of an elopement were protected from exiting the building and that the WG alarm would alert staff if a resident was near the elevator. The DON and the LNHA further stated that there were residents that were awake, alert, and oriented, that were allowed to have the code. The surveyor asked about the facility criteria and protocol for providing the code to those residents, the DON stated that it was done verbally. When asked if there was a policy related to residents being allowed to have the code, they stated that they did not have one. When asked for a list of residents that had the code at that time, the DON stated she did not one.When asked about an investigation into the incident that Resident #2 had on 4/7/26, the DON and the LNHA stated that they recalled discussing the fall. When asked about how the resident was able to leave their assigned unit, the DON referenced that there was a statement provided by staff that Resident #3 allowed Resident #2 go down on the elevator. When asked what action the facility took in response to the incident to ensure that does not happen again the DON stated that she interviewed Resident #3; the team discussed the incident and decided that Resident #3 would be transferred to a different unit. When asked if any other actions were taken, both the DON and the LNHA stated that the incident was not an elopement, it was a fall that did not need to be reported, and Resident #3 had been moved to another unit. When asked if facility reported the incident to the department of health, both DON and LNHA stated that the incident was a fall and did not need to be reported, and that they moved Resident #3 to another unit. An interview was (continued on next page)

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