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	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Marcella LLC	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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Complaint # 185832, 186185 Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to administer medications within the scheduled medication administration times. The deficient practice was identified for 2 of 2 residents (Resident # 12, # 159) reviewed for significant medication errors. The deficient practice was evidenced by the following: 1.) On 07/16/2025 at 10:16 AM, the surveyor observed Resident # 12 in bed in their room. At that time, he/she declined to be interviewed due to experiencing pain. The resident displayed facial grimacing as he/she spoke. A review of Resident # 12's Electronic Medical Record (EMR) under Orders revealed that Resident # 12 was prescribed Morphine Sulfate (medication used to treat pain) ER (Extended Release) 15 milligrams (mg) tablet to be given one time a day for Chronic Pain. He/she was also prescribed gabapentin (medication used to treat nerve pain) capsule 300mg to be given at 9:00 AM and 1:00 PM for nerve pain. A review of Resident # 12's Care Plan located in the EMR revealed a focus that Resident # 12 has chronic pain related to physical disability, multiple wounds, and neuropathy that was initiated on 2/19/2025. The Care Plan revealed an intervention to, Administer analgesia (Morphine ER and Oxycodone IR; Tylenol) as per orders . A review of the Medication Audit Report for Resident # 12 revealed that Morphine Sulfate ER 15 mg to be given at 9:00 AM was given on the following date and times: 7/5/25 - 10:35 AM 7/12/25 - 11:32 AM 7/13/25 - 10:50 AM A review of the Medication Audit Report for Resident # 12 revealed that gabapentin 300 mg to be given at 9:00 AM and 1:00 PM was given on the following date and times: 7/5/25 - 10:32 AM 7/5/25 - 15:17 PM (1 PM dose) 7/7/25 - 2:12 (1PM dose) 7/10/25 - 2:27 PM (continued on next page)

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.

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/11/25 - 2:13 PM 7/12/25 - 11:32 (9 AM dose) 7/12/25 - 2:20 PM (1 PM dose) 7/13/25 - 10:51 AM (9:00 AM) 7/13/25 - 2:35 PM (1:00 PM) On 7/22/2025 at 11:04 AM during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) # 1 replied that the nurses may not document the medication as administered at the administration time due to various distractions. She confirmed that Resident # 12 does take their medications for pain. On the same date at 11:16 AM during an interview with the surveyor, the Director of Nursing (DON) replied, One hour before and one hour after when the surveyor asked how early and how late can a medication be administered past the scheduled time. A review of the facility policy titled, Medication Administration implemented on 9/1/2024 revealed that, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . The policy also reflected that, 10. Ensure that the six right of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time . 2.) A review of Resident # 159’s admission record revealed that he/she was admitted with but not limited to paroxysmal atrial fibrillation (an irregular heartbeat that starts and stops on its own), neuropathy (damage or disease affecting the nerves outside the brain and spinal cord), and asthma (inflammation and narrowing of airways that affects the lungs). A review of Resident # 159's Electronic Medical Record (EMR) under Orders revealed that Resident # 159 was prescribed gabapentin (medication used to treat nerve pain) 300 milligrams (mg) capsule to be given three times a day for neuropathy. He/she was also prescribed metoprolol succinate (medication used to treat high blood pressure) ER (extended release) 25 mg tab one time a day for hypertension. He/she was also prescribed dabigatran etexilate mesylate (a medication used to thin blood) 150mg two times a day for atrial fibrillation. He/She was also prescribed Advair diskus inhalation aerosol powder (a medication used to treat asthma) 500 MCT/ACT (micrograms that is given per activated clotting time) one puff two times a day for asthma. A review of Resident # 159's Care Plan located in the EMR revealed a focus that Resident # 159 was on anticoagulant therapy (dabigatran Etexilate Mesylate) related to a-fib was initiated on 04/22/2025. The Care Plan revealed an intervention to, Administer anticoagulant medication as per orders . A review of the Medication Audit Report for Resident # 159 revealed that Gabapentin 300 mg to be given at 2:00 PM was given on the following date and times: 4/23/23 – 3:10 PM 4/24/25 – 3:09 PM (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Audit Report for Resident # 159 revealed that dabigatran etexilate mesylate150 mg to be given at 9:00 PM was given on the following date and times: 4/22/25- 11:30 PM 4/23/25- 2:03 AM 4/24/25-10:09 PM A review of the Medication Audit Report for Resident #159 revealed that Advair diskus inhalation aerosol powder 500-50 mcg/act to be give at 9:00 PM was given on the following date and times: 4/23/25-10:55 PM 4/24/25-10:10 PM On 7/22/2025 at 9:55 AM during an interview with the surveyor, the Licensed Practical Nurse said medications should be given within one hour before or after their scheduled time to ensure the effectiveness of the medications. On the same date at 10:01 AM during an interview with the surveyor, Director of Nursing (DON) said that medications could be given an hour before up to an hour after their scheduled time and signed out when given. The DON also said that if a medication was to be given late, the doctor was to be called, and an order would need to be given for that medication. A review of the facility policy titled, Medication Administration implemented on 9/1/2024 revealed that, “12, b. Administer with in 60 minutes prior to or after scheduled time unless otherwise ordered by physician.” N.J.A.C.§ 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interviews, record review, and review of facility documentation, it was determined that the facility failed to ensure infection control practices were followed for the handling and storage of respiratory equipment for 1 of 2 residents reviewed for respiratory care (Resident #92).On 7/16/2025 at 10:06 AM, during rounds the surveyor observed Resident #92 laying in bed in their room with the nasal cannula (a tube used to deliver oxygen through the nose). The tube was labeled 7/13/2025 and coiled directly on top of the oxygen concentrator (a medical device that delivers extra oxygen to the resident). The tube was not in a bag and exposed to air. On 7/17/2025 at 9:04 AM, during rounds the surveyor observed Resident #92 lying flat in bed. The oxygen tubing was now bagged, but continued to be labeled with the date 7/13/2025, indicating the tubing has been previously exposed and potentially reused.On 7/18/2025 at 12:18 PM, during rounds the surveyor observed Resident #92's nebulizer mask (a mask used to deliver aerosolized medication through the nose) and tubing was exposed and open to air on top of a stuffed animal on the windowsill. The nebulizer mask and tubing was not in a bag and exposed to air. A review of Resident # 92's admissions record revealed that, Resident # 92 was admitted with but not limited to atherosclerotic heart disease of native coronary artery without angina pectoris (a buildup of fatty deposits in the arteries of the heart, which can slow blood flow, however not having chest pain).A review of Resident #92's Electronic Medical Record revealed an active physician's order with a state date of 02/03/2025 for oxygen at 2 liters via nasal cannula as needed (PRN) for shortness of breath, wheezing, or if the SP02 (a device that measures oxygen level) falls below 93%.During an interview on 07/18/2025 at 11:06 AM with the surveyor, the Infection Preventionist (IP) said that all respiratory equipment should be kept in a bag when not in use and changed weekly for infection control. The IP further stated, if the respiratory equipment is found open to air, it should be thrown away and replaced. During an interview on 07/22/2025 at 10:04 AM with the surveyor, the Licensed Practical Nurse (LPN) #1 said that respiratory equipment should be stored in a bag and labeled with a date and name and kept in the resident's room. LPN # 1 further stated that oxygen tubbing is changed weekly on Wednesday night, and if it is found open to air, it would be discarded and changed for infection control.During an interview on 07/22/2025 at 12:02 PM with the surveyor, the Director of Nursing (DON) said the respiratory equipment should be kept in a plastic bag, not open to air, when not in use for infection control.A review of a facility provided policy titled Oxygen Administration, implemented on 09/01/2024 revealed under section, Policy Explanation and Compliance Guidelines: that, 5. b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. and 5. e. Keep delivery devices covered in plastic bag when not in use.8:39-19.4 (k)