STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801**

(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
F0000	INITIAL COMMENTS Complaint # 2800328 Census: 142 Sample Size: 3 A complaint survey was conducted on 3/5/26 and 3/6/26, to determine compliance with 42 CFR Part 483 for Long Term Care facilities. During the survey, a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.12(a)(1) F 600 as the facility failed to ensure staff did not neglect to carry out a physician's order to send a resident (Resident #1), who had [NJ Ex Order 26, 4B] [redacted] and a NJ Ex Order 26, 4B1 immediately to the hospital. On NJ Ex Order 26, 4B1, the Assistant Director of Nursing (ADON #1) informed the surveyor that on [NJ Ex Order 26, 4B] Resident #1 had a [NJ Ex Order 26, 4B] [redacted] and the resident's Medical Doctor (MD #1) ordered the resident to be transferred to [NJ Ex Order 26.4(b)(1] for evaluation and ADON #2 did not carry out the order. ADON #1 stated that later that day, MD #1 was at the facility conducting rounds, when she was alerted Resident #1 was still in the facility and she was "upset" and immediately sent the resident to the [NJ Ex Order 26.4] ADON #1 stated Resident #1 later [NJ Ex Order 26.] that day in the [NJ Ex Order 26.4] During an interview on [redacted] MD #1 stated that on [redacted] she ordered Resident #1 be sent to the [NJ Ex Order 26.] via [NJ Ex O] [redacted] for NJ Ex Order 26, 4B1. MD #1 continued that she had arrived at the facility on NJ Ex Order 26, 4B1, for scheduled rounds of her residents, and the Licensed Practical Nurse (LPN #2) informed her at 10:10 AM, that Resident #1 was still in the facility and [NJ Ex O] was not called. MD #1 stated that she spoke to ADON #2, who she had given the orders to, and ADON #2 told MD #1 that they were waiting on NJ Ex Order 26, 4B1 prior to calling [NJ Ex O] MD #1 stated that she informed ADON #2 that Resident #1 needed to be immediately sent to [NJ Ex Order 26.4(b)(1] [redacted]), and that waiting on [redacted] was not appropriate for the resident's condition.	F0000		03/30/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

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F0000	Continued from page 1 The Administration was notified of the F 600 IJ and was provided with the IJ template on 3/5/26 at 2:30 PM. A Removal Plan (RP) was submitted by the facility on 3/6/26 at 10:38 AM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the immediacy including Resident #1 was sent to the hospital and expired there. On 3/3/26, the U. S. FOIA (b) (2) met with the U.S. FOIA (b) (6)) to review and reinforce the facility's acute transfer review process, unit rounding procedures, and clinical oversight of residents experiencing an acute change in condition. On 3/5/26, the U. S. FOIA (b) (2) met with the U. S. FOIA and reinforced expectations related to timely and accurate documentation, physician notification, and escalation of care when residents experience an acute change in condition. On 3/5/26, the U. S. FOIA (b) (2) provided ongoing education to all licensed nursing staff on the following; physician notification of residents' changes in condition, documentation of physician's orders, carrying out a physician's order, change in condition assessment and emergency response, resident neglect, abuse, and prevention. The U. S. FOIA (b) will provide ongoing oversight of the U. S. FOIA to ensure continued monitoring of changes in condition, physician/provider notification, and documentation of clinical interventions. ADON #2 no longer works for the facility, and the clinical team reviewed all sub-acute charts and there were no additional discrepancies identified. The surveyor verified the implementation of the Removal Plan on-site on 3/6/26, and determined the immediacy was removed as of 3/6/26 at 10:38 AM.	F0000		03/30/2026
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the	F0600	Resident # 1 is no longer in the facility. Resident # 1 was transferred to NJ Ex Order 26, 4B1 on NJ Ex Order 26, 4B1 All residents have the potential to be affected by this practice. On 03/06/2026, the Director of Nursing provided education to licensed nursing staff on physician notification requirements related to changes in residents' conditions, emphasizing documentation of	04/17/2026

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F0600 SS = SQC-J	Continued from page 2 resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Complaint #2800328 Based on interviews, record review, and review of pertinent documents, it was determined that the facility failed to ensure staff did not [NJ Ex Order 26.4(b)] carry out a physician's order to send a resident (Resident #1) immediately to the hospital, who had [NJ Ex Order 26, 4B] and a NJ Ex Order 26, 4B1. The resident was sent later that day to [NJ Ex Order 26.4(b)(1)] by the physician and the resident [redacted] at [NJ Ex Order 26.4(b)(1)] the [NJ Ex Order 26, 4B1]. This deficient practice was identified for 1 of 3 residents reviewed for [NJ Ex Order 26] (Resident #1). On 3/5/26 at 9:00 AM, the Assistant Director of Nursing (ADON #1) informed the surveyor that on [NJ Ex Order 26,] Resident #1 had a NJ Ex Order 26, 4B1 and the resident's Medical Doctor (MD #1) ordered the resident to be transferred to [NJ Ex Order 26.4(b)(1)] for evaluation and ADON #2 did not carry out the order. ADON #1 stated that later that day, MD #1 was at the facility conducting rounds, when she was alerted Resident #1 was still in the facility and she was "upset" and immediately sent the resident to the [NJ Ex Order 26.4] ADON #1 stated Resident #1 later [NJ Ex Order 26] in [NJ Ex Order 26.4(b)(1)]. ADON #1 stated that ADON #2 [NJ Ex Order 26.4] from the facility on [NJ Ex Order], for unrelated reasons. During an interview on [redacted] MD #1 stated that on [NJ Ex Order 26] she ordered Resident #1 be sent to the NJ Ex Order 26.4(b)(1) for NJ Ex Order 26, 4B1. MD #1 continued that she had arrived at the facility on NJ Ex Order 26, 4B1 for scheduled rounds of her residents, and the Licensed Practical Nurse (LPN #2) informed her at 10:10 AM, that Resident #1 was still in the facility and [NJ Ex O] was not called. MD #1 stated that she spoke to ADON #2, who she had given the orders to, and ADON #2 told MD #1 that they were waiting on NJ Ex Order 26, 4B1 prior to calling [NJ Ex O] MD #1 stated that she informed ADON #2 that Resident #1 needed to be immediately sent to the NJ Ex Order 26.4(b)(1) and that waiting on [NJ Ex Order 26, 4B1] was not appropriate	F0600	Continued from page 2 communication, and the following of a physician's transfer orders without unnecessary delays. On 3/6/2026, the facility Director of Nursing and Vice President of Clinical Services provided ongoing education to all licensed nursing staff regarding change-in-condition management and clinical protocols. On 3/26/2026, the Director of Nursing conducted an audit of residents who experienced a change in condition and were transferred to the emergency room within the past thirty (30) days, with no unusual occurrences or deficient practices identified. The facility Administrator, Director of Nursing or designee will audit five residents who experienced a change in condition or were transferred to the hospital and review licensed staff responses twice weekly for two weeks, followed by weekly audits for an additional two weeks. The Administrator or Director of Nursing will present the audit findings, including identified clinical deficiencies, if any, to the Quality Assurance Committee for review and to determine the need for further performance improvement initiatives or reporting to the Clearing House Coordinator. 4/17/2026	04/17/2026

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F0600 SS = SQC-J	Continued from page 3 for the resident's condition. The facility's failure to implement their [NJ Ex Order] and [NJ Ex Order 26] policy to ensure all residents were protected from [NJ Ex Order 26] when staff [NJ Ex Order 26.4(D)] a physician's order to send Resident #1 immediately to [NJ Ex Order 2] for evaluation, placed Resident #1 as well as all residents at risk for [NJ Ex Order 26] This posed the likelihood for serious harm, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26, 4B1, when MD #1 ordered Resident #1 to be sent to [NJ Ex Order 2] and the order was not immediately carried out. The facility's Administration was notified of the IJ situation on 3/5/26 at 2:30 PM. The facility submitted an acceptable Removal Plan (RP) on 3/6/26 at 10:38 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 3/6/26, and determined the immediacy was removed as of 3/6/26 at 10:38 AM. The evidence is as follows: A review of the facility's "Abuse Investigation and Reporting" policy dated 6/15/25, included all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported…Procedure: Role of the Administrator 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual; 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation…4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of an investigation…Role of the Investigator: The Individual conducting the investigation will, as a minimum review the completed document forms; review the resident's medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 4 medical condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident… A review of the facility's "Reportable Events Policy" dated 5/1/25, included it is the policy of the facility to ensure that all reportable events, incidents, allegations, and operational disruptions that may impact the health, safety, or welfare of residents are promptly identified, investigated, documented, and reported to the appropriate regulatory authorities. Purpose: to establish a standardized process to…protect resident safety and welfare…Types of Reportable Events: resident safety events; allegations or suspicions of abuse, neglect, or exploitation… A review of the facility's "Physician's Orders and Notifications" policy dated 5/1/25, included; the facility will notify the resident's physician promptly for specified events and whenever there is a change in condition that may require medical assessment or treatment change…A. Events Requiring Prompt Notification (minimum): Notify the resident's attending physician promptly for the following (not exhaustive): acute change in mental status, new or worsened confusion, or sudden behavior changes…significant change in vital signs (blood pressure, heart rate, respiration rate) from baseline or defined thresholds…any event that may require [ER] transfer or hospital admission…B. timing Expectations: Immediate (within minutes – same shift): life-threatening or potentially life-threatening changes (respiratory compromise, hemodynamic instability, seizure)… A review of the facility's "Change in Condition Policy" dated 5/1/25, included the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a significant change requiring notification. Situations requiring notification include: 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: This includes: a. life-threatening conditions, or b. clinical complications… On 3/5/26 at 9:00 AM, the surveyor was informed	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 5 by ADON #1, that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the [redacted] immediately on [redacted] and the resident [redacted] ADON #1 continued that ADON #2 was made aware by nursing of the resident's [redacted], and ADON #2 called MD #1, who ordered the resident to be sent to [redacted] immediately. ADON #1 stated ADON #2 ignored the order and kept the resident in the facility because of the census numbers and administration pressure to keep residents in-house. ADON #1 stated that ADON #2 did not make herself or the [redacted] aware of the situation, and she had a history of going [redacted] and that ADON #2 felt she could provide the resident better treatment than in the [redacted] ADON #1 stated that MD #1 came into the facility at 10:00 AM, for her scheduled rounds and at 10:10 AM, LPN #2 informed MD #1 that Resident #1 was still in the facility. MD #1 was "upset" and MD #1 immediately sent Resident #1 to [redacted] who [redacted] there that day. On 3/5/26 at 9:10 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #1. A review of the Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted]. A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident had [redacted]. A review of Resident #1's Vital Signs revealed on [redacted] the resident's [redacted]. (Normal range for adults [redacted] and [redacted] is [redacted] A review of the Progress Notes included the following notes: A Nursing Progress Note dated [redacted]	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 6 documented by the Registered Nurse (RN #1), included the resident was observed with NJ Ex Order 26, 4B1 accompanied NJ Ex Order 26, 4B1 The resident was encouraged to increase NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 remains a NJ Ex Orde on NJ Ex Order 26, 4B1 of NJ Ex Order 26, 4B1). Will continue to monitor NJ Ex Order 26, 4B1 A Physician Progress Note dated NJ Ex Order 26, 4B1 documented "Late Entry" by MD #1, included: "VERBAL ORDER at 9:33 AM GIVEN TO NURSING [ADON #2] TO SEND PATIENT OUT TO EMERGENCY ROOM DUE TO NJ Ex Order 26, 4B1." A Nursing Note dated NJ Ex Order 26, 4B1, documented by LPN #1, included during morning rounds, the resident was observed for changes in condition and vital signs. The resident was awake and NJ Ex Order 26.4(b)(1) but the resident appeared NJ Ex Order 26, 4B1 Vital signs were taken NJ Ex Order 26, 4B1 [ADON #2] was made aware and received orders for NJ Ex Order 26, 4B1 All orders were placed and [ADON #2] was waiting for a response from [MD #1]. A Provider Progress Note dated NJ Ex Order 26, 4B1 , documented "Late Entry" by ADON #2 and created on NJ Ex Order 2 at 10:05 AM, included that the writer (ADON #2) was notified by the float nurse regarding the resident's NJ Ex Order 26.4(b) ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was NJ Ex Order 26, 4B1 The resident was NJ Ex Order 26.4(b)(1) for NJ Ex Order 26, 4 and [MD #1] was contacted unsuccessfully initially. The U. S. FOIA (b) (2)) was immediately notified for assessment, and MD #1 gave order to send out at "9:59 AM." NJ Ex Order 26.4(b)(1)) was activated, and the resident remained NJ Ex Order 26.4(b)(1) at the time of transfer. A Nursing Progress Note dated NJ Ex Order 26, 4B1 documented by LPN #2, included that [MD #1] arrived, and NJ Ex Order 26, 4B1 . They were unable to obtain NJ Ex Order 26, 4B1 , and order recommended to send resident to NJ Ex due to NJ Ex Order 26	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 7 NJ Ex Order 26, 4B1. NJ Ex Order 26.4(b)(1) were called, and the resident was transported to NJ Ex Order 26 A Nursing Progress Note dated NJ Ex Order 26, 4B1 documented by LPN #1, included that the resident was admitted to the ER with a diagnosis of NJ Ex Order 26, 4B1 A Physician's Progress Note dated NJ Ex Order 26, 4B1, included "[the resident] was seen and examined at bedside…This morning noted to have NJ Ex Order 26, 4B1) and NJ Ex Order 26, 4B1 per nursing. [The resident] appears more NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1. Unable to provide detailed history due to NJ Ex Order 26, 4B1 …Assessment and NJ Ex Order 26, 4B1. NJ Ex Order 26, 4B1 NJ Ex O activated to transfer NJ Ex Order 26.4(A review of the "Order Audit Report," included a telephone order dated NJ Ex Order 26, 4B1 to send the resident to the NJ Ex for "emergency transfer" due to NJ Ex Order 26, 4B1. This order contradicted ADON #2's "Late Entry" note that they were unable to contact MD #1, and they did not receive an order to transfer the resident to the NJ Ex until "9:59 AM." On 3/5/26 at 10:40 AM, the surveyor interviewed MD #1, who stated on NJ Ex Order 26, 4B1, ADON #2 had called her regarding the resident's NJ Ex Order 26 MD #1 stated she instructed ADON #2 to call 911 and send the resident to the NJ Ex O MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their NJ Ex. MD #1 stated that LPN #2 informed her that "we were told to wait until you came in." MD #1 spoke to ADON #2, who stated they were waiting on NJ Ex Order 26, 4B1 prior to calling NJ Ex O MD #1 specified that the resident needed to be sent to the NJ Ex immediately and waiting for NJ Ex Order 26, 4B1 was not appropriate for the	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 8 resident's condition, and NJ Ex was called. MD #1 stated it was an "unfortunate event," and she was not sure if the U.S. FOIA or ADON #1 were made aware of the situation. On 3/5/26 at 10:50 AM, the surveyor interviewed the U. S. FOIA who stated that the facility was not made aware of the situation with Resident #1 not being immediately sent to NJ Ex Order 26.4(b)(1) until after the resident NJ Ex Order 26.4 The continued that ADON #2 had not made her aware and it was a "habit" of ADON #2's. The U. S. FOIA stated that MD #1's orders to immediately send Resident #1 to NJ Ex Order 26.4(b)(1) should have been followed, and the facility had investigated the incident. The U. S. FOIA stated she had reviewed the resident's progress notes and she had observed a "Late Entry" progress note created by ADON #2 on NJ Ex Order, that was dated NJ Ex Order 26, 4 In that note, ADON #2 documented the U. S. FOIA was made aware of the resident's NJ Ex Order 26, 4B1, but the U.S. FOIA stated it was not true. The U.S. FOIA stated that ADON #2 had written that note on 3/3/26, and immediately resigned and left the facility. The U.S. FOIA stated that the facility's corporate team was made aware on 2/25/26, and they conducted an investigation. The U.S. FOIA stated she was not interviewed. On 3/5/26 at 10:54 AM, the surveyor interviewed LPN #2, who stated LPN #1 obtained vital signs from Resident #1, and she informed her of the resident's NJ Ex Order 26, 4B1. LPN #2 continued that they notified ADON #2, who checked the resident and ordered NJ Ex Order 26, 4B1, and stated she would notify MD #1. LPN #2 stated that she had returned to passing out morning medications, and she had asked ADON #2 if they were "sending [the resident] NJ Ex Or and ADON #2 stated, "we're waiting on the doctor." LPN #2 stated that MD #1 came in, and she informed MD #1 the resident's latest NJ Ex and that the resident was still in NJ Ex Order 26.4(b)(1). LPN #2 stated she heard MD #1 say to send Resident #1 to the ER immediately. On 3/5/26 at 11:05 AM, the surveyor interviewed LPN #1, who stated on NJ Ex Order 26, 4 she took Resident #1's vital signs. LPN #1 stated upon finding the resident had NJ Ex Order 26 she notified ADON #2 and LPN #2 of the resident's J Ex Order 26 and NJ Ex Order 26, 4B1. LPN #1 stated the resident was normally NJ Ex Orde but they were NJ Ex Order 26, 4B1. LPN #1 stated that ADON #2 told her to order NJ Ex Order 26, 4B1, and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 9 LPN #2 took over. On 3/5/26 at 11:41 AM, the surveyor conducted a telephone interview with ADON #2, who stated, "I contacted and alerted the [redacted] and [MD #1] of the resident's condition. I initially spoke to the doctor at 9:30 AM, and [MD #1] stated to call [redacted] The surveyor asked ADON #2 why the resident had not been sent out until after 10:10 AM, and ADON #2 stated she did not recall. The surveyor then asked ADON #2 why nursing and MD #1 informed the surveyor that ADON #2 had told them to wait for MD #1 to come in, and ADON #2 did not respond. The surveyor then asked ADON #2 why she back dated two progress notes, and ADON #2 replied, "I was told not to write a note on [redacted] by the [redacted]. I decided to write a note on the day I [redacted] because it was the right thing to do." On 3/5/26 at 12:00 PM, the surveyor interviewed the [redacted] who stated that corporate did an investigation of the situation. The [redacted] stated that the situation was brought up because ADON #1 and ADON #2 did not get along. The surveyor asked if there was a delay in the resident being sent to the ER, and the [redacted] stated yes, it did seem that happened. At that time, the [redacted] provided the surveyor with an undated document that had not resident's name on it, that the [redacted] stated was the facility's complete investigation for the incident on [redacted] A review of the undated and untitled document that was provided by the [redacted] contained a one paragraph summary and a one paragraph conclusion with no resident's name, date of incident, or attached statements. The information provided was as follows: "Summary: The patient was noted to have a [redacted] reading during evaluation. Despite the [redacted], the patient remained [redacted] Vital signs showed a [redacted] and [redacted] throughout the assessment. The patient has a history o [redacted] Monitoring and evaluation were maintained, staff communicated with physician and no immediate signs of [redacted] or [redacted] were observed at time of evaluation.	F0600		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801**

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F0600 SS = SQC-J	Continued from page 10 Conclusion: Although the patient demonstrated [redacted] the presence of [redacted] Given the patient's significant [redacted], close physician communication and monitoring and further medical evaluation were recommended to determine the underlying cause of the [redacted] and to guide appropriate management. Patient was sent to the [redacted] via [redacted] [gender redacted] left the facility [redacted] An acceptable Removal Plan (RP) was received on 3/6/26 at 10:38 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the immediacy including; Resident #1 was sent to [redacted] and [redacted] there. On 3/3/26, the [redacted] met with the [redacted] to review and reinforce the facility's acute transfer review process, unit rounding procedures, and clinical oversight of residents experiencing an acute change in condition. On 3/5/26, the "Chief Nursing" met with the [redacted] and reinforced expectations related to timely and accurate documentation, physician notification, and escalation of care when residents experience an acute change in condition. On 3/5/26, the [redacted] provided ongoing education to all licensed nursing staff on the following; physician notification of residents' changes in condition, documentation of physician's orders, carrying out a physician's order, change in condition assessment and emergency response, resident neglect, abuse, and prevention. The [redacted] will provide ongoing oversight of the [redacted] to ensure continued monitoring of changes in condition, physician/provider notification, and documentation of clinical interventions. ADON #2 no longer works for the facility, and the clinical team reviewed all sub-acute charts and there were no additional discrepancies identified. The surveyor verified the implementation of the Removal Plan on-site on 3/6/26, and determined the immediacy was removed as on 3/6/26 at 10:38 AM. During a post survey interview with the [redacted] on 3/18/26 at 3:23 PM, the [redacted] informed the surveyor that the facility misplaced Resident #1's Universal Transfer Form that was sent with the	F0600		04/17/2026

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F0600 SS = SQC-J	Continued from page 11 resident to [NJ Ex Order 2] on [NJ Ex Order 2]. The [U. S. FOIA (b)] stated that the facility had contacted the hospital for a copy. N.J.A.C. 8:39-4.1(a)5; 27.1(a)	F0600		04/17/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to report an [NJ Ex Order 26.4(b)(1)] to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 3 residents reviewed for [NJ Ex Order 26] (Resident #1), and was evidenced by the following: On 3/5/26 at 9:00 AM, the surveyor was informed by the Assistant Director of Nursing (ADON #1), that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the hospital on [NJ Ex Order 26.4] for [NJ Ex Order 26, 4B1] and a [NJ Ex Order 26, 4B1].	F0609	Failure to follow to the Facility's Reportable Event Policy concerning Resident #1. All residents have the potential to be affected by this practice. On 3/16/2026, the facility reviewed and revised its Reportable Events Policy. On 3/25/2026, the Facility Administrator and Director of Nursing provided education to all staff on the updated Reportable Events Policy. The Facility Administrator and Director of Nursing or designee will review all residents who experienced a change in condition resulting in death within the facility on a weekly basis for four weeks. The Facility Administrator and Director of Nursing will present audit findings, including identified deficiencies, if any, to the Quality Assurance Committee for review to determine the need for further performance improvement initiatives and to assess whether the incident meets criteria as a reportable event. 4/17/2026	04/17/2026

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F0609 SS = D	Continued from page 12 ADON #1 continued that Resident #1's Medical Doctor (MD #1) came into the facility later that day, and MD #1 was "upset" that Resident #1 was still at the facility. ADON #1 stated that MD #1 immediately sent Resident #1 to [NJ Ex Order 26.4(b)(1)], who [NJ Ex Order 26] there that day. On 3/5/26 at 9:10 AM, the surveyor reviewed Resident #1's Electronic Medical Record (EMR) A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to: [NJ Ex Order 26, 4B1] . A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool dated [NJ Ex Order 26, 4B] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex Order 26, 4B1], which indicated the resident had [NJ Ex Order 26, 4B1] . A review of Resident #1's Vital Signs revealed on [NJ Ex Order 26, 4B1], the resident's [NJ Ex Order 26, 4B1]). (Normal range for [NJ Ex Order 26.4(b)(1)] and [NJ Ex] is [NJ Ex Order 26.4(b)(1)] A review of the Progress Notes included the following notes: A Nursing Progress Note dated [NJ Ex Order 26, 4B1], documented by the Registered Nurse (RN #1), included the resident was observed with [NJ Ex Order 26, 4B1] accompanied by very [NJ Ex Order 26, 4B1]. The resident was encouraged to increase [NJ Ex Order 26, 4B1] Will continue to monitor [NJ Ex Order 26, 4B1] A Physician Progress Note dated [NJ Ex Order 26, 4B1] AM, documented "Late Entry" by MD #1, included "VERBAL ORDER at 9:33 AM GIVEN TO NURSING	F0609		04/17/2026

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F0609 SS = D	Continued from page 13 [ADON #2] TO SEND PATIENT OUT TO [redacted] DUE TO [redacted]." A Provider Progress Note dated [redacted] documented "Late Entry" by ADON #2 and created on [redacted] at 10:05 AM, included that the writer (ADON #2) was notified by the float nurse regarding the resident's condition. ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was [redacted] noted. The resident was [redacted] for [redacted] and [MD #1] was contacted unsuccessfully initially. The [redacted]) was immediately notified for assessment, and MD #1 gave order to send out at "9:59 AM." [redacted]) was activated, and the resident remained [redacted] at the time of transfer. On 3/5/26 at 10:40 AM, the surveyor interviewed MD #1, who stated on [redacted], ADON #2 had called her regarding the resident's [redacted] MD #1 stated she instructed ADON #2 to call [redacted] and send the resident to [redacted]. MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their [redacted] had [redacted] MD #1 stated that LPN #2 informed her that "we were told to wait until you came in." MD #1 spoke to ADON #2, who stated they were waiting on [redacted] prior to calling [redacted] MD #1 specified that the resident needed to be sent to the ER immediately and waiting for [redacted] was not appropriate for the resident's condition, and [redacted] was called. MD #1 stated it was an "unfortunate event," and she was not sure if the [redacted] or ADON #1 were made aware of the situation. On 3/5/26 at 10:50 AM, the surveyor interviewed the [redacted], who stated that the facility was not made aware of the situation with Resident #1 not being immediately sent to [redacted] until after the resident [redacted] The [redacted] continued that ADON #2 had not made her aware and it was a "habit" of ADON #2's. The [redacted] stated that MD #1's orders to immediately send Resident #1 to the hospital should have been followed, and the facility had investigated the incident. The [redacted] stated she had reviewed the resident's progress notes and she had observed a "Late Entry" progress note created by ADON #2 on	F0609		04/17/2026

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F0609 SS = D	Continued from page 14 3/3/26, that was dated [NJ Ex Order 26]. In that note, ADON #2 documented the [redacted] was made aware of the resident's [NJ Ex Order 26, 4B1], but the [U. S. FOIA] stated it was not true. The [redacted] stated that ADON #2 had written that note on [NJ Ex Order], and immediately resigned and left the facility. On 3/5/26 at 11:05 AM, the surveyor interviewed LPN #1, who stated on [NJ Ex Order 26], she took Resident #1's vital signs. LPN #1 stated upon finding the resident had [NJ Ex Order 26] she notified ADON #2 and LPN #2 of the resident's [NJ Ex Order 26] and [NJ Ex Order 26, 4B1]. LPN #1 stated the resident was normally [NJ Ex Orde] but they were [NJ Ex Order 26, 4B1] LPN #1 stated that ADON #2 told her to order [NJ Ex Order 26, 4B1] and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and LPN #2 took over. On 3/5/26 at 1:30 PM, the surveyor met with the [U. S. FOIA P], who stated the facility should have reported the event to the NJDOH. A review of the facility's "Reportable Events Policy," dated 5/1/25, included it is the policy of the facility to ensure that all reportable events, incidents, allegations, and operational disruptions that may impact the health, safety, or welfare of residents are promptly identified, investigated, documented, and reported to the appropriate regulatory authorities. Purpose to establish a standardized process to…protect resident safety and welfare…Types of Reportable Events: resident safety events; allegations or suspicions of abuse, neglect, or exploitation… A review of the facility's "Abuse Reporting and Investigating" policy, dated 6/15/25, included all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management...An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately but no later than; two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury...	F0609		04/17/2026

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F0609 SS = D	Continued from page 15 NJAC 8:39-4.1(a)5	F0609		04/17/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the U. S. FOIA (b) (2) or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to thoroughly investigate an NJ Ex Order 26.4(b)(1) of a resident who was transferred to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 the same day to rule out NJ Ex Order 26.4 This deficient practice was identified for 1 of 3 residents reviewed for NJ Ex Order 26 (Resident #1), and was evidenced by the following: On 3/5/26 at 9:00 AM, the surveyor was informed by ADON #1, that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the hospital immediately on NJ Ex Order 26 , for NJ Ex Order 26, 4B1 and the resident NJ Ex Order 26 in NJ Ex Order 26.4(b)(1) that day. ADON #1 continued that ADON #2 was made aware by nursing of the resident's NJ Ex Order 26, 4B and ADON #2 called MD #1, who ordered the resident to be sent to the ER immediately. ADON #1 stated ADON #2 ignored the order and kept the resident in the facility because of the census numbers and administration pressure to keep residents in-house. ADON #1 stated that ADON #2 did not make herself or the U. S. FOIA (b) (2) aware of the situation, and she had a history	F0610	Resident #1 NJ Ex Order 26.4(b)(1) on NJ Ex Order 26, 4B1 Resident #1, who had NJ Ex Order 26, 4B1 NJ Ex Order 26.4(b)(1), with the family electing NJ Ex Order 26.4(b)(1) All residents have the potential to be affected by this practice. On 2/26/2026, the U. S. FOIA (b) (2) conducted a chart review of Resident #1 and developed a timeline following the resident's transfer to the emergency room; no evidence of abuse or neglect was identified. The U. S. FOIA (b) (2) conducted an audit of all resident deaths within the past sixty days and found no evidence of abuse or neglect. The Facility Administrator and Director of Nursing or designee will review all facility deaths weekly for four weeks. The Facility Administrator and Director of Nursing will present the audit findings, including identified deficiencies, if any, to the Quality Assurance Committee for review and to determine the need for further performance improvement initiatives or reporting to the Clearing House Coordinator. 4/17/2026	04/17/2026

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F0610 SS = D	Continued from page 16 of going "rogue" and that ADON #2 felt she could provide the resident better treatment than in the [redacted] ADON #1 stated that MD #1 came into the facility at 10:00 AM, for her scheduled rounds and at 10:10 AM, LPN #2 informed MD #1 that Resident #1 was still in the facility. MD #1 was "upset" and MD #1 immediately sent Resident #1 to [redacted] who [redacted] there that day. On 3/5/26 at 9:10 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #1. A review of the Face Sheet (an admission summary), revealed the resident was admitted to the facility with diagnoses that included but were not limited to; [redacted]. A review of the most recent Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident had [redacted]. A review of Resident #1's Vital Signs revealed on [redacted] the resident's [redacted] (Normal range for adults [redacted] and [redacted] is [redacted].) A review of the Progress Notes included the following notes: A Nursing Progress Note dated [redacted], documented by the Registered Nurse (RN #1), included the resident was observed with [redacted]. The resident was encouraged to increase [redacted] Will continue to monitor [redacted]. A Physician Progress Note dated [redacted], documented "Late Entry" by MD #1, included "VERBAL ORDER at 9:33 AM GIVEN TO NURSING	F0610		04/17/2026

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F0610 SS = D	Continued from page 17 [ADON #2] TO SEND PATIENT OUT TO [redacted] DUE TO [redacted]. A Nursing Note dated [redacted] documented by LPN #1, included during morning rounds, the resident was observed for changes in condition and vital signs. The resident was awake and [redacted] but the resident appeared [redacted]. Vital signs were taken: [redacted] [ADON #2] was made aware and received orders for [redacted]. All orders were placed and [ADON #2] was waiting for a response from [MD #1]. A Provider Progress Note dated [redacted] documented "Late Entry" by ADON #2 and created on 3/3/26 at 10:05 AM, included that the writer (ADON #2) was notified by the float nurse regarding the resident's condition. ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was responsive with [redacted] noted. The resident was [redacted] for [redacted] and [MD #1] was contacted unsuccessfully initially. The [redacted] was immediately notified for assessment, and MD #1 gave order to send out at "9:59 AM." [redacted] was activated, and the resident remained [redacted] at the time of transfer. A Nursing Progress Note dated [redacted] documented by LPN #2, included that [MD #1] arrived, and [redacted]. They were unable to obtain [redacted], and order recommended to send resident to ER due to [redacted] were called, and the resident was transported to [redacted]. A Nursing Progress Note dated [redacted] documented by LPN #1, included that the resident was admitted to the ER with a diagnosis of [redacted]	F0610		04/17/2026

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F0610 SS = D	Continued from page 18 A Physician's Progress Note dated NJ Ex Order 26, 4B1, included "[the resident] was seen and examined at bedside…This morning noted to have NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 per nursing. [The resident] appears more NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 able to provide detailed history due to NJ Ex Order 26, 4B1 changes…Assessment and Plan…acute NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 activated to transfer to NJ Ex Order A review of the "Order Audit Report" included a telephone order dated NJ Ex Order 26, 4B1 to send the resident to the ER for "emergency transfer" due to NJ Ex Order 26, 4B1. This order contradicted ADON #2's "Late Entry" note that they were unable to contact MD #1, and they did not receive an order to transfer the resident to the ER until "9:59 AM." On 3/5/26 at 10:40 AM, the surveyor interviewed MD #1, who stated on NJ Ex Order 26, 4B1 ADON #2 had called her regarding the resident's NJ Ex Order 26, 4B1 MD #1 stated she instructed ADON #2 to call NJ Ex Order 26, 4B1 and send the resident to the NJ Ex Order 26, 4B1 MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their NJ Ex Order 26, 4B1 MD #1 stated that LPN #2 informed her that "we were told to wait until you came in." MD #1 spoke to ADON #2, who stated they were waiting on NJ Ex Order 26, 4B1 prior to calling NJ Ex Order 26, 4B1 MD #1 specified that the resident needed to be sent to the NJ Ex Order 26, 4B1 immediately and waiting for NJ Ex Order 26, 4B1 was not appropriate for the resident's condition, and NJ Ex Order 26, 4B1 was called. MD #1 stated it was an "unfortunate event," and she was not sure if the U. S. FOIA Privacy or ADON #1 were made aware of the situation. On 3/5/26 at 10:50 AM, the surveyor interviewed the U. S. FOIA Privacy, who stated that the facility was not made aware of the situation with Resident #1 not being immediately sent to the NJ Ex Order 26, 4B1 until after the resident NJ Ex Order 26, 4B1 The U. S. FOIA Privacy continued that ADON #2 had not made her aware and it was a "habit" of ADON #2's. The U. S. FOIA Privacy stated that MD #1's orders to immediately send Resident #1 to the NJ Ex Order 26, 4B1 should	F0610		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801**

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F0610 SS = D	Continued from page 19 have been followed, and the facility had investigated the incident. The [redacted] stated she had reviewed the resident's progress notes and she had observed a "Late Entry" progress note created by ADON #2 on [redacted] that was dated [redacted]. In that note, ADON #2 documented the [redacted] was made aware of the resident's NJ Ex Order 26, 4B1, but the [redacted] stated it was not true. The [redacted] stated that ADON #2 had written that note on [redacted], and immediately [redacted] and left the facility. The [redacted] stated that the facility's corporate team was made aware on 2/25/26, and they conducted an investigation. The [redacted] stated she was not interviewed. On 3/5/26 at 10:54 AM, the surveyor interviewed LPN #2, who stated LPN #1 obtained vital signs from Resident #1, and she informed her of the resident's NJ Ex Order 26, 4B1. LPN #2 continued that they notified ADON #2, who checked the resident and ordered NJ Ex Order 26, 4B1, and stated she would notify MD #1. LPN #2 stated that she had returned to passing out morning medications, and she had asked ADON #2 if they were "sending [the resident] out," and ADON #2 stated, "we're waiting on the doctor." LPN #2 stated that MD #1 came in, and she informed MD #1 the resident's lates[redacted] and that the resident was still in the building. LPN #2 stated she heard MD #1 say to send Resident #1 to [redacted] immediately. On 3/5/26 at 11:05 AM, the surveyor interviewed LPN #1, who stated on [redacted] she took Resident #1's vital signs. LPN #1 stated upon finding the resident had [redacted] she notified ADON #2 and LPN #2 of the resident's [redacted] and NJ Ex Order 26, 4B1. LPN #1 stated the resident was normally [redacted] but they were [redacted]. LPN #1 stated that ADON #2 told her to order NJ Ex Order 26, 4B1, and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and LPN #2 took over. On 3/5/26 at 11:41 AM, the surveyor conducted a telephone interview with ADON #2, who stated, "I contacted and alerted the [redacted] and [MD #1] of the resident's condition. I initially spoke to the doctor at 9:30 AM, and [MD #1] stated to call [redacted] The surveyor asked ADON #2 why the resident had not been sent out until after 10:10 AM, and ADON #2 stated she did not recall. The surveyor then asked ADON #2 why nursing and MD #1 informed the surveyor that ADON #2 had told them to wait for MD #1 to come in, and ADON #2 did not respond. The	F0610		04/17/2026

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F0610 SS = D	Continued from page 20 surveyor then asked ADON #2 why she back dated two progress notes, and ADON #2 replied, "I was told not to write a note on [redacted], by the [redacted]. I decided to write a note on the day I [redacted] because it was the right thing to do." On 3/5/26 at 12:00 PM, the surveyor interviewed the [redacted], who stated that corporate did an investigation of the situation. The [redacted] stated that the situation was brought up because ADON #1 and ADON #2 did not get along. The surveyor asked if there was a delay in the resident being sent to [redacted] and the [redacted] stated yes, it did seem that happened. At that time, the [redacted] provided the surveyor with an undated document that had not resident's name on it, that the [redacted] stated was the facility's complete investigation for the incident on [redacted]. A review of the undated and untitled document that was provided by the [redacted] contained a one paragraph summary and a one paragraph conclusion with no resident's name, date of incident, or attached statements. The information provided was as follows: "Summary: The patient was noted to have a [redacted] reading during evaluation. Despite the [redacted], the patient remained [redacted] and [redacted] vital signs showed a [redacted] and NJ Ex Order 26, 4B1 throughout the assessment. The patient has a history of extensive comorbidities, which may contribute to fluctuations in [redacted] and overall clinical status. Monitoring and evaluation were maintained, staff communicated with physician and no immediate signs of NJ Ex Order 26, 4B1 or [redacted] were observed at time of evaluation. Conclusion: Although the patient demonstrated [redacted] the presence of [redacted] NJ Ex Order 26, 4B1, and maintained [redacted]. Given the patient's significant [redacted], close physician communication and monitoring and further medical evaluation were recommended to determine the underlying cause of the NJ Ex Order 26, 4B1 and to guide appropriate management. Patient was sent to the [redacted] via [redacted] [gender redacted] left the facility [redacted]	F0610		04/17/2026

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F0610 SS = D	Continued from page 21 A review of the facility's "Abuse Investigation and Reporting" policy, dated 6/15/25, included all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported…Procedure: Role of the Administrator 1. If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual; 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation…4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of an investigation…Role of the Investigator: The Individual conducting the investigation will, as a minimum review the completed document forms; review the resident's medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident… A review of the facility's "Reportable Events Policy," dated 5/1/25, included it is the policy of the facility to ensure that all reportable events, incidents, allegations, and operational disruptions that may impact the health, safety, or welfare of residents are promptly identified, investigated, documented, and reported to the appropriate regulatory authorities...6. Investigation Process. The facility will initiate an investigation within twenty-four hours of the reportable event. the investigation includes: interviewing staff involved and witnesses; reviewing medical records and care plans; evaluating contributing factors. 7. Root Cause Analysis (RCA). For serious events, the facility will conduct RCA to identify: system failures, environmental factors, staff training gaps, policy or procedural deficiencies. The RCA must include corrective actions and prevention strategies... N.J.A.C. 8:39-4.1(a)5	F0610		04/17/2026

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

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H0000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H0000		03/30/2026
S0000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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.	S0000		03/30/2026
H5790	UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM CFR(s): 8:43E-13.4(d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to retain a copy of the Universal Transfer Form (UTF) sent with a resident (Resident #1) to the [NJ Ex Order 26.4(b)(1) redacted] on [NJ Ex Order 26, redacted]. This deficient practice was identified for 1 of 3 residents reviewed (Resident #1), and was evidenced by the following: On 3/5/26 at 9:00 AM, the surveyor was informed by the Assistant Director of Nursing (ADON #1), that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to [NJ Ex Order 26.4(b)(1) redacted] immediately on [NJ Ex Order 26 redacted], for [NJ Ex Order 26, 4B redacted] and the resident in [NJ Ex Order 26.4(b)(1) redacted] that day. ADON #1 continued that ADON #2 was made aware by nursing of the resident's NJ Ex Order 26, 4B1 and ADON #2	H5790	A copy of the Universal Transfer Form for Resident #1 on [NJ Ex Order 26, 4B redacted] was misplaced. All residents have the potential to be affected by this practice. On 3/25/2026, the Director of Nursing provided education to licensed nursing staff on the importance of retaining the completed universal transfer form for facility records. On 3/25/2026, the Director of Nursing conducted an audit of residents who were transferred to the emergency room within the past thirty (30) days; no other deficient practice identified. The Director of Nursing or designee will audit five residents transferred to the hospital to ensure a copy of the universal transfer form is retained, twice weekly for two weeks, followed by weekly audits for an additional two weeks.The Director of Nursing will present audit findings, including identified deficiencies, if any, to the Quality Assurance Committee for review and to determine the need for further performance improvement initiatives.	04/17/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

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EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801

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H5790	Continued from page 1 called the resident's Medical Doctor (MD #1), who ordered the resident to be sent to the ER immediately. ADON #1 stated ADON #2 ignored the order and kept the resident in the facility because of the census numbers and administration pressure to keep residents in-house. ADON #1 stated that ADON #2 did not make herself or the Director of Nursing (DON) aware of the situation, and she had a history of going "rogue" and that ADON #2 felt she could provide the resident better treatment than in the hospital. ADON #1 stated that MD #1 came into the facility at 10:00 AM, for her scheduled rounds and at 10:10 AM, LPN #2 informed MD #1 that Resident #1 was still in the facility. MD #1 was "upset" and MD #1 immediately sent Resident #1 to the hospital who expired there that day. On 3/17/26 at 4:47 PM, the surveyor made a post-survey request for the Licensed Nursing Home Administrator (LNHA) to provide a copy of the UTF sent with Resident #1 to [NJ Ex Order 2] or [NJ Ex Order 26, 4B] During a post survey interview with the LNHA on 3/18/26 at 3:23 PM, the LNHA informed the surveyor that the facility misplaced Resident #1's Universal Transfer Form that was sent with the resident to [NJ Ex Order 2] or [NJ Ex Order 26, 4B] The LNHA stated that the facility had contacted the hospital for a copy.	H5790	Continued from page 1 4/17/2026	04/17/2026
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to notify the Clearing House Coordinator of a nurse's incompetence as mandated by the State of New Jersey when the Assistant Director of Nursing (ADON #2) neglected a physician's order to transfer a resident (Resident #1) with NJ Ex Order 26, 4B1 and a NJ Ex Order 26, 4B1 to the NJ Ex Order 26.4(b)(1) on [NJ Ex Order 26]. The resident was transferred later that day by their Medical Doctor (MD #1) and [NJ Ex Order 26] that day in [NJ Ex Order 26.4(b)(1)]. ADON #2 resigned from the facility on [NJ Ex Order 2], for unrelated reasons. This deficient practice was identified for 1 of 3 residents reviewed for [NJ Ex Order 2] (Resident #1), and the findings were as followed:	S0560	ADON# 2 no longer works for the facility. All residents have the potential to be affected by this practice. On 3/6/2026, the Director of Nursing provided education to licensed nursing staff on physician notification requirements related to changes in residents' conditions, emphasizing documentation of communication, and the following of physician's transfer order without unnecessary delays. On 3/26/2026, the Director of Nursing conducted an audit of residents who experienced a change in condition and were transferred to the emergency room within the past thirty (30) days; no unusual occurrences or deficient practices were identified that required reporting to the Clearing House Coordinator. The facility Administrator, Director of Nursing, or designee will audit five residents who experienced a change in condition or were transferred to the	04/17/2026

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S0560	Continued from page 2 Reference: New Jersey Administrative Code Title 13 Law and Public Safety Chapter 45E Health Care Professional Reporting Responsibility. Subchapter 3: 13:45E-3.1 Notification to the Clearing House Coordinator by a Health Care Entity a) Except as provided in (c) below, a health care entity shall file a report with the Clearing House Coordinator concerning a health care professional who is employed by, under contract to render professional services to, has clinical privileges granted by that health care entity, or who provides such services pursuant to an agreement with a health care services firm or staffing registry if: 1) For reasons relating to health care professional's impairment, incompetency or professional misconduct, which incompetency or professional misconduct relates adversely to patient care or safety, the health care entity: i) Summarily or temporarily revokes or suspends or permanently reduces, suspends or revokes the health care professional's full or partial clinical privileges or practice; ii) Removes the health care professional from the list of eligible employees of health services firm or staffing registry; iii) Discharges the health care professional from the staff of the health care entity; or iv) Terminates or rescinds a contract with the health care professional to render professional services: On 3/5/26 at 9:00 AM, the surveyor was informed by ADON #1, that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the hospital immediately on NJ Ex Order 26, 4B1 [redacted] and the resident [redacted] in [redacted] that day. ADON #1 continued that ADON #2 was made aware by nursing of the resident's [redacted] and ADON #2 called MD #1, who ordered the resident to be sent to [redacted] immediately. ADON #1 stated ADON #2 ignored the order and kept the resident in the facility because of the census numbers and administration pressure to keep residents in-house. ADON #1 stated that ADON #2 did not make herself or the Director of Nursing (DON) aware of the situation, and she had a history of going "rogue" and that ADON #2 felt she could provide the resident better treatment than in the	S0560	Continued from page 2 hospital and review licensed staff responses twice weekly for two weeks, followed by weekly audits for an additional two weeks. The Administrator or Director of Nursing will present the audit findings, including identified clinical deficiencies, if any, to the Quality Assurance Committee for review and to determine the need for further performance improvement initiatives or reporting to the Clearing House Coordinator. 04/17/2026	04/17/2026

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S0560	Continued from page 3 NJ Ex Order 26.4 ADON #1 stated that MD #1 came into the facility at 10:00 AM, for her scheduled rounds and at 10:10 AM, LPN #2 informed MD #1 that Resident #1 was still in the facility. MD #1 was "upset" and MD #1 immediately sent Resident #1 to the NJ Ex Order 26. who NJ Ex Order 26 there that day. On 3/5/26 at 9:10 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #1. A review of the Face Sheet (an admission summary), revealed the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 A review of the most recent Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1 indicating the resident had NJ Ex Order 26, 4B1 . A review of Resident #1's Vital Signs revealed on NJ Ex Order 26, 4B1 the resident's NJ Ex Order 26, 4B1 . (Normal range for adults NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) is NJ Ex Order 26.4(b)(1).) A review of the Progress Notes included the following notes: A Nursing Progress Note dated NJ Ex Order 26, 4B1 documented by the Registered Nurse (RN #1), included the resident was observed with NJ Ex Order 26, 4B1 The resident was encouraged NJ Ex Order 26, 4B1 Will continue to monitor NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b) and overall condition. A Physician Progress Note dated NJ Ex Order 26, 4B1 documented "Late Entry" by MD #1, included "VERBAL ORDER at 9:33 AM GIVEN TO NURSING [ADON #2] TO SEND PATIENT OUT TO NJ Ex Order 26.4(b)(1) DUE TO NJ Ex Order 26, 4B1 ."	S0560		04/17/2026

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S0560	Continued from page 4 A Nursing Note dated NJ Ex Order 26, 4B1 documented by LPN #1, included during morning rounds, the resident was observed for changes in condition and vital signs. The resident was awake and responsive, but the resident appeared NJ Ex Order 26, 4B1 Vital signs were taken: NJ Ex Order 26, 4B1 [redacted] [ADON #2] was made aware and received orders for NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. All orders were placed and [ADON #2] was waiting for a response from [MD #1]. A Provider Progress Note dated NJ Ex Order 26, 4B1, documented "Late Entry" by ADON #2 and created on NJ Ex Order 26, 4B1, included that the writer (ADON #2) was notified by the float nurse regarding the resident's condition. ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was NJ Ex Order 26, 4B1 noted. The resident was repositioned for comfort, and [MD #1] was contacted unsuccessfully initially. The Director of Nursing (DON) was immediately notified for assessment, and MD #1 gave order to send out at "9:59 AM." NJ Ex Order 26.4(b)(1) was activated, and the resident remained NJ Ex Order 26.4(b)(1) at the time of transfer. A Nursing Progress Note dated NJ Ex Order 26, 4B1 documented by LPN #2, included that [MD #1] arrived, and NJ Ex Order 26, 4B1 They were unable to obtain NJ Ex Order 26, 4B1, and order recommended to send resident to NJ Ex [redacted] due to NJ Ex Order 26 [redacted] NJ Ex Order 26.4(b)(1) were called, and the resident was transported to the NJ Ex O [redacted] A Nursing Progress Note dated NJ Ex Order 26, 4B1 documented by LPN #1, included that the resident was admitted to the ER with a diagnosis of NJ Ex Order 26, 4B1 [redacted] A review of the "Order Audit Report" included a	S0560		04/17/2026

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EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801

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S0560	Continued from page 5 telephone order dated NJ Ex Order 26, 4B1 to send the resident to the NJ Ex for "emergency transfer" due to NJ Ex Order 26, 4B1. This order contradicted ADON #2's "Late Entry" note that they were unable to contact MD #1, and they did not receive an order to transfer the resident to NJ Ex Order 2 until "9:59 AM." On 3/5/26 at 10:40 AM, the surveyor interviewed MD #1, who stated on NJ Ex Order 26, 4B1, ADON #2 had called her regarding the resident's NJ Ex Order 26, MD #1 stated she instructed ADON #2 to call 911 and send the resident to the NJ Ex MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their NJ Ex [redacted]. MD #1 stated that LPN #2 informed her that "we were told to wait until you came in." MD #1 spoke to ADON #2, who stated they were waiting on NJ Ex Order 26, 4B1 prior to calling NJ Ex MD #1 specified that the resident needed to be sent to the NJ Ex immediately and waiting for NJ Ex Order 26, 4B1 was not appropriate for the resident's condition, and NJ Ex was called. MD #1 stated it was an "unfortunate event," and she was not sure if the DON or ADON #1 were made aware of the situation. On 3/5/26 at 10:50 AM, the surveyor interviewed the DON, who stated that the facility was not made aware of the situation with Resident #1 not being immediately sent to the NJ Ex Order 26, until after the resident NJ Ex Order 26.4 The DON continued that ADON #2 had not made her aware and it was a "habit" of ADON #2's. The DON stated that MD #1's orders to immediately send Resident #1 to the NJ Ex Order 26 should have been followed, and the facility had investigated the incident. The DON stated she had reviewed the resident's progress notes and she had observed a "Late Entry" progress note created by ADON #2 on 3/3/26, that was dated NJ Ex Order 26. In that note, ADON #2 documented the DON was made aware of the resident's NJ Ex Order 26, 4B1, but the DON stated it was not true. The DON stated that ADON #2 had written that note on 3/3/26, and immediately NJ Ex Order 26.4 and left the facility. The DON stated that the facility's corporate team was made aware on 2/25/26, and they conducted an investigation. The DON stated she was not interviewed. On 3/5/26 at 10:54 AM, the surveyor interviewed LPN #2, who stated LPN #1 obtained vital signs from	S0560		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801

(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
S0560	Continued from page 6 Resident #1, and she informed her of the resident's NJ Ex Order 26, 4B1. LPN #2 continued that they notified ADON #2, who checked the resident and ordered NJ Ex Order 26, 4B1 and stated she would notify MD #1. LPN #2 stated that she had returned to passing out morning medications, and she had asked ADON #2 if they were "sending [the resident] out," and ADON #2 stated, "we're waiting on the doctor." LPN #2 stated that MD #1 came in, and she informed MD #1 the resident's latest [redacted] and that the resident was still in the building. LPN #2 stated she heard MD #1 say to send Resident #1 to the [redacted] immediately. On 3/5/26 at 11:05 AM, the surveyor interviewed LPN #1, who stated on [redacted], she took Resident #1's vital signs. LPN #1 stated upon finding the resident had [redacted] she notified ADON #2 and LPN #2 of the resident's [redacted] and NJ Ex Order 26, 4B1. LPN #1 stated the resident was normally [redacted] but they were [redacted]. LPN #1 stated that ADON #2 told her to order NJ Ex Order 26, 4B1 and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and LPN #2 took over. On 3/5/26 at 11:41 AM, the surveyor conducted a telephone interview with ADON #2, who stated, "I contacted and alerted the DON and [MD #1] of the resident's condition. I initially spoke to the doctor at 9:30 AM, and [MD #1] stated to call [redacted] The surveyor asked ADON #2 why the resident had not been sent out until after 10:10 AM, and ADON #2 stated she did not recall. The surveyor then asked ADON #2 why nursing and MD #1 informed the surveyor that ADON #2 had told them to wait for MD #1 to come in, and ADON #2 did not respond. The surveyor then asked ADON #2 why she back dated two progress notes, and ADON #2 replied, "I was told not to write a note on [redacted] by the Licensed Nursing Home Administrator (LNHA). I decided to write a note on the day I [redacted] because it was the right thing to do." On 3/5/26 at 12:00 PM, the surveyor interviewed the LNHA, who stated that corporate did an investigation of the situation. The LNHA stated that the situation was brought up because ADON #1 and ADON #2 did not get along. The surveyor asked if there was a delay in the resident being sent to the [redacted] and the LNHA stated yes, it did seem that happened. The surveyor asked if the facility reported ADON #2 to the Clearing House Coordinator, and the LNHA	S0560		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801**

(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
S0560	Continued from page 7 responded no.	S0560		04/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801**

(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
F0000	INITIAL COMMENTS An on-site revisit was conducted on 04/22/2026 in relation to the 03/06/2026 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061423	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET , DOVER, New Jersey, 07801**

(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
H0000	Initials Comments An on-site revisit was conducted on 04/22/2026 in relation to the 03/06/2026 Complaint survey. The facility was found to be in compliance with all of the standards in the New Jersey Administrative Code Title 8, Chapter 8:43E, Enforcement of Licensure Regulations Standards for Licensure of Long Term Care Facilities.	H0000		
S0000	Initial Comments An on-site revisit was conducted on 04/22/2026 in relation to the 03/06/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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