STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s: NJ#157563, #158377, #159018, #162913, #164582, #165792, #169759, #171067, #171307, #173245 Survey Date: 5/31/2024 Census: 148 Sample: 30 sample + 2 closed records = 32 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		7/15/24

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

Electronically Signed | 06/24/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint # NJ157563 Based on observation, interview, and review of facility documentation, it was determined the facility failed to maintain a comfortable and homelike environment for resident rooms on one (1) of six (6) nursing units of the facility observed (2nd floor Unit). The evidence of this deficient practice includes:	F 584	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Room 215 and Room 217- Noticeable [redacted] of [redacted] carpet and [redacted] in room. The carpets were deeply cleaned. " Room 217-carpets in room visibly frayed. Carpets were repaired/replaced as needed.	

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F 584	Continued From page 2 On 5/23/24 at 10:28 AM, during the initial tour of the 2nd floor Unit, the surveyor observed the following: Room 215 and Room 217- Noticeable [NJ Exec Or] of [NJ Exec] carpet and [NJ Exec Orde] in room Room 217-carpets in room visibly frayed Room 218-carpets in room were visibly frayed and stained. Room 219- large black stain observed between door and window bed. On 5/28/24 at 12:28 PM, the surveyor observed the following on the 2nd Floor Unit: Room 215 and Room 217-[NJ Exec Or] of [NJ Exec] carpet and [NJ Exec Orde] remained. Room 217 and 218- carpets remained frayed and stained. On 5/29/24 at 10:06 AM, during a follow-up tour of the 2nd floor Unit, the surveyor observed the following: Room 215- carpet frayed at door entrance, room to hallway transition strip missing, room [NJ Exec Or] remained. Room 217- carpet ripped/frayed, [NJ Exec Or] remained. Room 219- carpet frayed, stained black. Room 218- carpet in front of door ripped/frayed. Room 220- carpet at entrance of room ripped/frayed, room to hallway transition strip is missing. Room 223 - carpet by B bed ripped/frayed, room to hallway transition strip missing, carpet near [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b] Room 201- carpet ripped in 2 areas in between the beds.	F 584	" Room 218-carpets in room were visibly frayed and stained. Carpets were repaired/replaced as needed. " Room 219- large black stain observed between door and window bed. The carpets were deeply cleaned. " Room 220- carpet at entrance of room ripped/frayed, room to hallway transition strip is missing. Carpets were repaired/replaced as needed. Transition was applied. " Room 223 - carpet by B bed ripped/frayed, room to hallway transition strip missing, carpet near [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b] The carpets were deeply cleaned. Carpets were repaired/replaced as needed. Transition was applied. " Room 201- carpet ripped in 2 areas in between the beds. Carpets were repaired/replaced as needed. " Room 203- carpet Stained. Carpets were repaired/replaced as needed. " No residents were adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Software program implementation initiated as of 5/19/2024 to ensure all	

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F 584	Continued From page 3 Room 203- carpet Stained On 5/29/24 at 10:16 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that he does environmental rounds such as checking hot water temperatures. The U.S. FOIA further stated that he was just starting to do daily environmental rounds with the housekeeping (HK) department. On that same date and time, the U.S. FOIA stated that he was aware that the carpets in Room 215 and Room 217 were NJ Exec because the NJ Exec Order 26.4b1 into the two carpeted rooms on NJ Exec Order 26.4. The U.S. FOIA stated that when a staff member finds something broken or needing repair, the staff will write it in the "Daily Maintenance Log" book. When he does his daily rounds, he will check the book and initial next to the room number then he will put in a work order. If it was an emergency repair, the staff will then page him. On 5/29/24 at 12:28 PM, the surveyor reviewed the above carpet and room concerns with the U.S. FOIA (b)(6) U.S. FOIA (b)(6) . The U.S. FOIA (b)(6) stated that the maintenance department conducts environmental rounds, and the HK department conducts cleaning rounds. The surveyor requested any documentation of the environmental and HK audits or rounding. A review of the April and May 2024 "Daily Maintenance Log" binder, located at the 2nd floor Nurses Station, did not reveal any entries regarding the condition of the carpets.	F 584	maintenance needs and repairs are tracked and completed in a timely manner. " The administrator educated the U.S. FOIA (b) (6) to complete daily rounds to inspect carpets and report findings to the administrator. " The administrator educated the U.S. FOIA (b) (6) to complete daily rounds for presence of odors and report findings to the administrator. " The Director of Maintenance will complete weekly maintenance audits specific to carpet conditions document findings. " The Director of Housekeeping will complete weekly audits specific to odors and documents findings. IV. MONITORING OF CORRECTIVE ACTIONS: " The administrator or designee will review maintenance and housekeeping weekly audits for 4 weeks to ensure maintenance or housekeeping concerns are addressed in a timely manner. The administrator will ensure implementation of software program to ensure all work orders are completed in a timely manner. The results of audits will be presented to Quality Assurance Committee quaterly for review to ensure continued compliance.	

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F 584	Continued From page 4 On 5/30/24 at 10:42 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated that every day he does environmental rounding of the whole building. He further stated that he does random rooms and checks the carpets, wheelchairs, curtains, blinds, etc. If something was broken or needed repair, he would report it to maintenance. The [redacted] stated that any maintenance repairs observed during the rounds would be told to maintenance verbally and that he did not write it in the maintenance log. The U.S. FOIA further stated that he was aware that the carpets in Rooms 215 and Room 217 were NJ Exec and had an NJ Exec Or because the NJ Ex Order 26.4(b)(1). He stated that the carpets were cleaned with a shampoo machine. The surveyor reviewed the random audits provided by the NJ Exec and there was no documentation of the frayed or stained rugs and that the maintenance department was notified. On 5/30/24 at 12:02 PM, the U.S. FOIA (b) (6) stated that he did environmental rounds with the maintenance dept weekly but was unable to provide any documentation or maintenance audits. A review of the facility's policy Resident Right-Safe/Clean/Comfortable/Homelike Environment dated 5/01/2024, revealed that the facility will provide a safe, clean, comfortable, homelike environment such a manner to acknowledge and respect residents' rights. The resident has a right to a safe, clean, comfortable, and homelike environment. NJAC 8:39-4.1(a) 11, 31.4(a)	F 584		
F 600 SS=F	Free from Abuse and Neglect	F 600		7/15/24

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F 600	Continued From page 5 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 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: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident was free from NJ Ex Order 26.4(b)(1). This deficient practice occurred for one (1) of four (4) residents reviewed for NJ Ex Order 26 (Resident #6) and was evidenced by the following: Refer to 610 F On 5/21/24 at 11:04 AM, Resident #6 stated the following: On NJ Exec Order 26.4 a U.S. FOIA (b)(6) and a Certified Nursing Assistant (CNA) held NJ Exec O of the residents NJ Exec Orde down against the residents will to obtain NJ Exec Order 26.4b1 that the resident did not agree to. As a result the resident sustained NJ Exec Order 26.4b1 . Resident #6 then stated that he/she was NJ Ex Order 26.4(b)(1) and NJ Exec O reported the	F 600	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Resident #6 was informed of any procedure or NJ Exec Order 26.4b to be completed. Resident #6 was educated on the reason/need for procedure. " Resident #6 will be seen NJ Exec Order 26.4b1 " Education was provided to staff regarding residents□ rights including right to be informed and right to refuse care. " Statements were obtained from all staff/vendors involved in any allegation of NJ Exec Order 26 " A team member will accompany the vendor into the room for any lab	

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F 600	Continued From page 6 incident to the facility (RN on duty) on the next day NJ Exec Order 26.4b1 The resident informed the surveyor that he/she had NJ Exec Order 26.4b1 on NJ Exec Order 26.4 and wanted to know why he/she needed to have NJ Exec Order 26.4b1 again on NJ Exec Order 26.4. On 5/22/24 at 9:30 AM, the surveyor again interviewed Resident #6, regarding the NJ Exec Order 26.4b on NJ Exec Order 26.4. The resident stated that she had NJ Ex Order 26.4(b)(1) on NJ Exec Order 26.4b and was not informed of the result. On NJ Exec Order 26.4b the U.S. FOIA (b)(6) came wanted to NJ Exec Order 26.4b1 again. The resident refused. When Resident #6 inquired why NJ Exec Order had to be NJ Ex Order 26 again, the U.S. FOIA (b)(6) could not provide the rationale for the NJ Ex Order 26.4(b)(1). Resident #6 stated that he/she she did not agree to the NJ Exec Order 2 being NJ Ex Order 26 again. The U.S. FOIA (b)(6) then asked the CNA to hold the resident's NJ Exec Orde down for the NJ Exec Order 26.4b1 and the resident was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 After the NJ Exec Orde NJ Exec Orde, he/she developed NJ Exec Order 26.4b1 . On 5/23/24 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b)(6) about the concerns that were reported by Resident #6. The U.S. FOIA (b) stated that she was aware of the issue with the NJ Exec Orde NJ Exec Order 2 on NJ Exec Order 26.4 and an incident report was generated. The NJ Exec Orde added that she did not investigate the issue because she "knew what happened" and confirmed it was not reported to the New Jersey Department of Health (NJDOH) until after surveyor inquiry on 5/23/24. On 5/23/24 at 12:41 PM, the U.S. FOIA (b) provided the Incident/Accident (I/A) Report. According to the I/A Report provided dated NJ Exec Order 26. timed 5:00 PM, there was a diagram that indicated NJ Exec Order 26 on the NJ Exec Order 26.4b1 A Registered Nurse (RN) documented on NJ Ex Order 26.4(b), "Resident #6 stated on NJ Exec Order 26.4 that	F 600	work/procedure. " Refer to F610 POC " Resident to be visited by Director of Social Services for NJ Exec Order 26.4b check. " No residents were adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Abuse and Neglect policies were revised by the Administrator* to ensure the mentioned processes and protocols are followed. " A facility wide education was conducted on abuse/neglect prevention and reporting. The abuse and neglect policy was reviewed with all staff. " Licensed nurses were educated to inform residents of reasoning for lab work prior to obtaining labs " Reportable Events will be submitted to the Department of Health as per state regulations. " Statements were obtained from all staff/vendors involved in any allegation of abuse. " Education will be provided to vendors	

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F 600	Continued From page 7 the NJ Exec Order 26 happened when the CNA assisted with NJ Exec Order 26.4b on NJ Exec Order 26." The Interdisciplinary notes dated NJ Exec Order 26 indicated the following: " Resident #6 stated that their NJ Exec O was held tight while NJ Exec was being NJ Exec Order 26.4 The line of the NJ Exec Order 26.4b1 could be seen on NJ Exec Order 26.4b1 (NJ days later on NJ Exec Order 26.4b. Monitor for worsening. Educate technician. A review of the Progress Notes dated NJ Exec Order 26 revealed that the resident reported the incident to to the RN on NJ Exec Order 26. The Resident Representative visited the resident on NJ Exec Order 26, observed the NJ Exec Order 26.4b and reported it to the administrative staff. The resident reported the NJ Exec Order 26 incident to the NJ Exec Order 26.4b1 . The NJ Exec Orde informed the facility and reported the incident to the U.S. FOIA (b) on NJ Exec Order 26. There was no investigation of the NJ Exec Order 26.4b1 and it was not reported to the NJDOH until 5/23/24. The facility did not initiate an investigation even after the incident was reported on NJ Exec Order 26.4b1 . The CNA was not asked to provide a statement regarding the incident. The U.S. FOIA (b)(6) was not contacted and did not have a statement attached to the I/A Report provided dated NJ Exec Order 26. There was no documented evidence that the U.S. FOIA (b)(6) was educated as stated in the Interdisciplinary Notes dated NJ Exec Order 26.4b On 5/23/24 at 01:14 PM, the surveyor interviewed the U.S. FOIA (b) in the presence of the survey team regarding the NJ Ex Order 26.4(b)(1) made by Resident #6 to the surveyor. The U.S. FOIA (b) stated that she was already aware of the NJ Exec Order 26.4b on the NJ Exec Order 26.4b1 . The U.S. FOIA (b) stated that the incident actually took place on U.S. FOIA (b)(6) The U.S. FOIA (b)	F 600	on Abuse/Neglect Policy and reporting. " The Administrator and Director of Nursing will complete thorough investigations into allegations of abuse and neglect. " All collected statements will be thoroughly reviewed. IV. MONITORING OF CORRECTIVE ACTIONS: " The Director of Nursing or designee will educate all nursing staff to provide residents/families with lab results in a timely manner before completion date. " The Director of Nursing or designee will educate the nurses to inform the residents before any type of lab work/procedure when appropriate before completion date. " The Administrator and Director of Nursing will conduct facility wide education on Abuse/Neglect and reporting before completion date. " The Administrator or designee will provide all vendors with facility□s Abuse/Neglect Prevention and reporting policy before completion date. " The administrator or designee will ensure proper investigations are completed for allegations of abuse. Administrator or designee will review all documentation before submission to the Department of Health. " All allegations of abuse and reportable events will be reviewed by the	

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F 600	Continued From page 8 confirmed that an investigation had not yet been started ([redacted] days later). On 5/28/24 at 12:23 PM, the surveyor interviewed the CNA who the resident [redacted] held their [redacted] down for the [redacted]. The CNA denied that she held Resident #6's [redacted] down for [redacted] on [redacted] The CNA stated that she requested not to be assigned to Resident #6. There was no evidence that the facility provided regarding the U.S. FOIA (b)(6) was in-serviced on [redacted] or had reported the incident to the [redacted] On 5/28/24 at 02:30 PM, the [redacted] provided the surveyor with the investigation summary and conclusion. A statement from Resident #6 dated [redacted] days after the incident occurred) which documented that both the U.S. FOIA (b)(6) and the CNA held Resident #6's [redacted] down to [redacted]. The statement from the U.S. FOIA (b)(6) was dated [redacted] days after the incident) and indicated that the resident was being [redacted] and the U.S. FOIA (b)(6) asked the CNA to help. An undated statement from the RN indicated that she heard the Resident #6 [redacted] and she went to the room while the [redacted] was being [redacted] A statement dated [redacted] from the CNA, that was already in the room, and documented that she heard the resident asking why he/she had to have [redacted] again. The resident [redacted]" and she came to [redacted] the resident. Further review of the above information, the facility did not investigate timely or report the incident to the NJDOH as required as revealed by the Long Term Care Reportable Event Summary was completed on [redacted] after the surveyor	F 600	Quality Assurance committee quarterly to ensure continued compliance.	

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F 600	Continued From page 9 inquiry[redacted] days later after the facility was made aware of the incident. On 5/29/24 at 12:41 PM, the surveyor interviewed the[redacted]. The[redacted] stated that Resident #6 reported the incident on[redacted] and she stated she was not made aware of aware of any prior[redacted] against staff. A review of the facility's Abuse Investigation and Reporting Policy that was provided by the[redacted] included the procedures that should have been followed for an investigation as follows: The Policy Dated: 05/01/24 revealed: Intent: 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. 3. The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation. 4. The Administrator will suspend immediately	F 600		

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F 600	Continued From page 10 any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented. On 5/31/24 at 11:56 AM, the survey team met with U.S. FOIA (b)(6) [redacted] There was no additional information provided by the facility management.	F 600		
F 607 SS=F	NJAC 8:39-4.1(a)(5) Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 607	Continued From page 11 but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Complaint #NJ171307 Based on interview, record review and review of pertinent documents, it was determined that the facility failed to develop comprehensive policies and consistently implement procedures to prevent and investigate [redacted] by failing to ensure: a) a system was in place to pre-screen contracted staff timely and provide training on the current facility [redacted] policies, b) all residents who may have been [redacted] were identified and a documented system was in place to rule out [redacted] c) all involved persons, including potential witnesses, were identified, and a documented interview was completed per facility policy, and d) a system was in place to ensure a complete and thorough investigation occurred and was documented. This deficient practice occurred for two (2) of two (2) residents (Resident #42 and #85) who NJ Exec Order 26.4b1 by a [redacted] certified nurse aide. This deficient practice was evidenced by the following: Refer to 610F On 5/22/24 at 10:40 AM, the U.S. FOIA (b)(6)	F 607	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Resident #85 o A personalized care plan was implemented for at risk for [redacted] related to an allegation of [redacted]. o NJ Exec Order 26.4b1 provided through social worker visits. o [redacted] consults in place to address [redacted] needs. o On-going [redacted] consult, [redacted]. " Resident #42 o A personalized care plan was implemented for at risk for [redacted] related to an allegation of [redacted] o NJ Exec Order 26.4b1 provided through social worker visits. o [redacted] consults in place to address [redacted] needs. o On-going [redacted] consult, [redacted]. " Refer to F610 POC	

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F 607	Continued From page 12 U.S. FOIA (b)(6) provided the survey team with the "Abuse Prohibition Policy and Procedures" that was required as part of the entrance documents provided by the facility. The unsigned document, contained 19 unnumbered pages, included, but was not limited to the following: -Freedom from Abuse, Neglect, and Exploitation Policy/Procedure, dated 6/01/23. Intent: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. Procedure: This policy will include: 1. Free from Abuse and Neglect. 2. Free from Misappropriation/Exploitation. 3. Free from Involuntary Seclusion. 4. Right to be Free from Physical Restraints. 5. Right to be Free from Chemical Restraints. 6. Not Employ/Engage Staff with Adverse Actions. 7. Develop/Implement Abuse/Neglect, etc. Policies. 8. Reporting of Reasonable Suspicion of a Crime. 9. Reporting of Alleged Violations. 10. Investigate/Prevent/Correct Alleged Violation. -The next page revealed Subject: Freedom from Abuse, Neglect, Misappropriation, Exploitation with the same Intent. Procedure: 1. The resident has the right to be free from	F 607	" No residents were adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Abuse and Neglect policy were reviewed and revised by Administrator to ensure mentioned processes and protocols are implemented. The policy was updated to specify procedures to follow to screen contracted employees and education of contracted employees. " A facility wide education was conducted on abuse/neglect prevention and reporting. The abuse and neglect policy was reviewed with all staff. " Education was provided to vendors on Abuse/Neglect Policy and reporting. " The Administrator and Director of Nursing will complete thorough investigations of allegations of abuse and neglect. All collected statements will be thoroughly reviewed. " The Reportable Event Guide will be followed by facility to ensure all steps of investigations are	

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F 607	Continued From page 13 abuse, neglect, misappropriation of resident property and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, or involuntary seclusion. [The remainder of the page was left blank and there was no documented process or procedure]. -Another page revealed the Subject: Freedom from Abuse, Neglect, etc. and had the same Intent. Procedure: 1. The facility will develop and implement written and policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of resident and misappropriate of resident property. b. Establish policies and procedures to investigate any such allegations, and c. Include training. [The remainder of the page was left blank and there was no documented process or procedure]. -Another page revealed the Subject: Reporting of Reasonable Suspicion of a Crime and Alleged Violations and had the same Intent. Procedure: ... 4. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: a. Have evidence that all alleged violations are thoroughly investigated. b. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. c. Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance	F 607	followed thoroughly. The guide specifies steps to be followed to identify any other residents who could be potentially affected. " A grievance form will be completed by the Director of Social Services for any allegation of abuse. IV. MONITORING OF CORRECTIVE ACTIONS: " The Administrator and Director of Nursing will conduct facility wide education on Abuse/Neglect and reporting before completion date. " The Administrator or designee will provide all vendors with facility□s Abuse/Neglect Prevention and reporting policy before completion date. " The administrator or designee will ensure proper investigations are completed for allegations of abuse. Administrator or designee will review all documentation before submission to the Department of Health. " All allegations of abuse and reportable events will be reviewed by the Quality Assurance Committee to ensure continued compliance. " The Administrator will review all grievances upon completion and all grievances will be presented during the quarterly Quality Assurance meeting to ensure compliance.	

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F 607	Continued From page 14 with State Law ... 9. The facility Risk Manager or Designee will be responsible for the Form completion when a staff member does not complete one and will also be responsible for the investigation and documentation of final findings. The document did not specify procedures to follow to screen contracted employees, educate contracted employees, identify, and protect other residents that may have been abused when an allegation of abuse was made, and what specific procedures were to be followed to conduct a thorough investigation. A review of a Reportable Event Record (RER) that had been submitted to the Department of Health (DOH) by the facility U.S. FOIA (b)(6) U.S. FOIA (b) (6 on NJ Ex Order 26.4(b)(1 at 12:34 PM revealed: Type of Incident: NJ Ex Order 26.4(b)(1) . Narrative: Resident #85 stated NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 by the nursing assistant who got him/her ready for bed on NJ Exec Order 26.4b1 evening NJ Exec Order 26.4b1. Resident #85 stated heard Resident #42, speaking in a NJ Exec Order 26.4b1" and stated the NJ Exec Order 26.4b1 and that's why he/she reported this issue today NJ Exec Order 26.4b1 Resident #42, upon interview [untimed] stated that during care a few days ago, a NJ Exec Orde male nursing assistant with NJ Exec Order 26.4b1 entered the room, took the resident do the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 What interventions were implemented after the incident: Both residents were interviewed and NJ Exec Order 26.4b1	F 607		

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F 607	Continued From page 15	F 607		

assessment were completed immediately. Family and physicians were notified. NJ Ex Order 26.4(b)(1) was notified. Investigation on going.

The undated Investigation Summary submitted by the facility revealed:

Investigation:

On NJ Exec Order 26.4b1, Resident #85 reported to the nurse on duty, that he/she did not like the way the male nursing assistant who provided care on NJ Exec Order 26.4b1 evening and NJ Exec Order 26.4b1. The nurse informed the U.S. FOIA (b) who went to further interview Resident #85. Resident #85 stated that on NJ Exec Order 26.4b1 the aide was NJ Exec Order 26.4b1 "

Resident #85 stated that on NJ Exec Order 26.4b1, heard Resident #42 NJ Exec Order 26.4b1] in the hallway about the NJ Exec Order 26.4b1."

U.S. FOIA (b) and a [NJ Exec Order 26.4b1 staff interviewed Resident #42.

Resident #42 explained maybe two nights before, around midnight, a male went into his/her room, led to the NJ Exec Order 26.4b1 and while in the NJ Exec Order 26.4b1 the aide NJ Exec Order 26.4b1 on his/her NJ Exec Order 26.4b1].

Resident #42 stated that he/she told his/her family member (FM). About the incident.

The U.S. FOIA (b) placed a call to the FM.

The involved Certified Nurse Aide (CNA) was interviewed and denied the accusation. The CNA stated he was assisting Resident #42 to the NJ Exec Ord when the FM arrived at the floor, the CNA left

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F 607	Continued From page 16 when FM entered the room. Both patients were interviewed by [redacted]. The roommate of Resident # 85 was present in the room during all interactions and denied seeing or hearing any incidents. Both Residents had complete [redacted] assessment and [redacted] noted. Summary/Conclusion: -The [redacted] was Unsubstantiated. -According to the staff, Resident #42's FM visited right when the CNA was with Resident #42 and entered the room before the CNA left. -The CNA stated he only assisted the patient at that time before his/her FM visited and that the FM met the CNA in the [redacted] with the resident when he was sitting Resident #42 [redacted] and left the resident in the care of the FM. - "All alert and oriented patients" on the unit who were cared for by the employee were interviewed and did not report any concerns. Interventions: -Both Resident #42 and #85 were educated on reporting incidents immediately. -FM was educated on reporting incidents regardless of the patients' cognition or description of the incident.	F 607		

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F 607	Continued From page 17 -Both patients were assessed, [NJ Exec Order 26.4b1] assessment was done with no [NJ Exec Order 26.4b1] noted. -Both patients were [NJ Exec Order 26.4b1] -Incident reported to the [U.S. FOIA (b) (6)] -The employee was an [NJ Exec Order 25] staff; he was suspended immediately pending the investigation and will not return. On 5/23/24 at 10:30 AM, the surveyor reviewed the electronic Medical Record (eMR) for Resident #85 as follows: The Admission Record (AR, or face sheet, an admission summary) revealed diagnoses which included, but were not limited to; [NJ Exec Order 26.4b1] A review of the 22-page current Care Plan (CP) with a target date of [NJ Exec Order 26.4b] and including resolved items, did not reveal a Focus related to the [NJ Ex Order 26.4(b)(1)] of [NJ Exec Order 26.4b1] that occurred on [NJ Exec Order 26.4b] and was reported on [NJ Exec Order 26.4b]. The multi-disciplinary progress notes (PN) from [NJ Exec Order 26.4b1] did not show a nurses note or physician documentation related to the [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1] that occurred on [NJ Exec Order 26.4b] and was reported on [NJ Exec Order 26.4b1]. A [NJ Ex Order 26.4(b)(1)] or any other type of assessment related to the [NJ Ex Order 26.4(b)(1)] of [NJ Exec Order 26] [NJ Exec Order2] was not located in the eMR or paper medical record.	F 607		

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F 607	Continued From page 18 The most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated the resident scored a [NJ Exec Order] on the brief interview for mental status (BIMS) which indicated the resident was [NJ Exec Order 26.4b1]. A review of Resident #42's EMR showed the following: The AR had diagnoses that included, but were not limited to, [NJ Exec Order 26.4b1] The current 21-Page CP, including resolved items, and had a target date of [NJ Exec Order 26], did not show a Focus related to the [NJ Exec Order 26.4b1] that occurred on [NJ Exec Order 26.4b] and was reported on [NJ Exec Order 26.4b]. Reviewed all interdisciplinary PN from [NJ Exec Order 26.4b] through [NJ Exec Order 26.4b1] which did not reveal a nurses note or physician documentation related to the [NJ Exec Order 26.4b1] that occurred on [NJ Exec Order 26.4b] and was reported on [NJ Exec Order 26.4b1] A [NJ Ex Order 26.4(b)(1)] or any other type of assessment related to the [NJ Ex Order 26.4(b)(1)] of [ ] as not located in the eMR or paper medical record. A review of the most recent Quarterly MDS indicated the resident scored a [NJ Exec O] on the BIMS which indicated the resident was [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b1]. On 5/28/24 at 9:20 AM, the [U.S. FOIA (b)(6)] provided the surveyor with what he stated was the completed facility investigation and provided the RER. The surveyor	F 607		

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F 607	Continued From page 19 then requested all documents from the [U.S. FOIA (b)], in the presence of the [U.S. FOIA (b)(6)] regarding statements and any investigative documents reviewed. The [U.S. FOIA (b)] pointed to her type-written summary and stated, "those were the statements." On 5/28/24 at 10:30 AM, the surveyor asked the [U.S. FOIA (b)(6)] what the process was regarding hiring agency staff and educating them on [NJ Ex Order 26.4]. The [U.S. FOIA (b)(6)] stated, the agency staff had an orientation and was in-serviced by the [U.S. FOIA (b)] and the process was the same as for a new employee. The process was the same for all new employees and stated was "not sure" of the process. The surveyor asked if the [NJ Exec Order 2] policy that was provided was the only facility [NJ Exec Order 2] policy and the [U.S. FOIA (b)(6)] stated he will look for any other specific [NJ Ex Order 26] policy. On 5/28/24 at 11:10 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] who stated she had been at the facility for [NJ Ex Order 26.4(b)(1)]. She stated she was the [U.S. FOIA (b)(6)]. The surveyor asked what the protocol for [NJ Exec Order 26] was. She stated if she received an [NJ Ex Order 26.4(b)(1)] she would inform the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)]. She stated she interviewed residents and family and would document in the grievance book. At that same time, the surveyor asked the [US FOIA (b)] if she had a grievance for [NJ Exec Order 2] from Resident #85 and #42 and she stated, "not that she was aware of." The surveyor asked what constituted [NJ Exec Order 26] and the [U.S. FOIA (b)] stated if a resident felt they were [NJ Ex Order 26.4(b)(1)], or any signs of [NJ Exec Order 26] that she would interview the resident and anyone involved. The surveyor asked if there was a process for the investigation and she stated she would look for it.	F 607		

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F 607	Continued From page 20 On 5/28/24 at 11:32 AM, the survey team met with the U.S. FOIA (b)(6) [redacted]. The surveyor asked if there was anything that was provided as guidance to staff regarding what was supposed to completed when an NJ Ex Order 26.4(b)(1) occurred. At that time, when asked about the investigation related to Resident #85 and #42, the [redacted] confirmed there were no other individual statements taken from any other residents. The [redacted] then confirmed he did not review the investigation as he was not at the facility during that time. A review of the facility provided investigation revealed there were two statements attached, one untimed statement from the accused CNA, dated [redacted] and another document with a typed statement, undated and untimed. There were no assessments, interviews from other staff, residents, the FM or any of the alleged documents referenced per the RER, and there were no attached NJ Ex Order 26.4(b)(1). The education for the CNA that was attached to the facility provided investigation included a copy of an [redacted] policy from a completely different facility located in another town and did not have the same company name. On 5/28/24 at 01:01 PM, the [redacted] provided a second [redacted] policy titled, Abuse Investigation and Reporting Policy, dated 5/01/24 which included: Intent: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to	F 607		

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F 607	Continued From page 21	F 607		

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.

3. The Administrator will suspend immediately any employee who has been accursed of resident abuse, pending the outcome of the investigation.

5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented.

Role of the Investigator:

The individual conducting the investigation will, as a minimum.

-Review the completed documentation forms.

-Review the resident's medical record to determine events leading up to the incident.

- Interview the person(s) reporting the incident.

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F 607	Continued From page 22 - Interview the resident. -Interview other residents to who the accused employee provides care or services. - Interview the residents's roommate, family members, and visitors. The following guidelines will be used when conducting interviews: ... -Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. On 5/29/24 at 12:52 PM, the above concerns were shared with the U.S. FOIA (b) (6) and there was no additional information provided during the exit conference held on 05/31/24 at 11:56 AM.	F 607		
F 609 SS=E	NJAC 8:39-4.1(a)5 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	F 609		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 609	Continued From page 23 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: Complaint #NJ171307 #NJ164582 Based on observations, interviews, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to report as required to the New Jersey Department of Health (NJDOH) within two hours: a) an [redacted] of [redacted] that occurred for two residents by a staff member, b.) an [redacted], and c.) an NJ Ex Order 26.4(b)(1). This deficient practice occurred for four (4) of six (6) residents reviewed for [redacted] (Residents #35, #42, #85, and #104) and was evidenced by the following: Refer to 610F 1. Surveyor#1 (S#1) reviewed a Reportable Event Record (RER) confirmation sheet that indicated the RER was submitted to the NJDOH by the	F 609	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Alleged [redacted] for [redacted] #35, #42, #85, and #104 were reported to NJDOH. " Refer to F610 POC. " Facility wide education completed on reporting alleged violations putting emphasis on timing, reporting within 2 hours of allegation to appropriate agencies, investigating injuries of unknown origin, and any allegation of abuse. " Residents were not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 609	Continued From page 24 facility U.S. FOIA (b)(6) at 12:34 PM (one day after the incidents were reported). The RER revealed: Today's date: NJ Ex Order 26.4(b)(1) Date of Event: NJ Ex Order 26.4(b)(1) Time of Event: 6:30 PM Was this a significant event? "Yes". Type of Incident: NJ Ex Order 26.4(b)(1) . Narrative: Resident #85 stated [redacted] was NJ Exec Order 26.4b1 by the nursing assistant who got him/her ready for bed on NJ Exec Order 26.4b1 [redacted] Resident #85 stated heard Resident #42, speaking in a NJ Exec Order 26.4b1 " and stated the NJ Exec Order 26.4b1 " and that's why he/she reported this issue today NJ Ex Order 26.4(b)(1) . Resident #42, upon interview [untimed] stated that during care a few days ago, a NJ Exec Orde male nursing assistant with NJ Exec Order 26.4b1 entered the room, took the resident do the NJ Exec Order 26.4b1 and put NJ Exec Order 26.4b1 [redacted] The undated Investigation Summary submitted by the facility revealed: Investigation: On NJ Exec Order 26.4b , Resident #85 reported to the nurse on duty, that the resident did not like the way the male nursing assistant who provided care on NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] . The nurse informed the NJ Exec Orde who went to further interview Resident #85. Resident #85 stated that on NJ Exec Order 26.4b the aide was NJ Exec Order 26.4b [redacted] ." Resident #85 stated that on NJ Exec Order 26.4b1	F 609	WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the same deficient practice. " All grievances were reviewed for potential allegations of NJ Ex Order 26.4 No discrepancies were identified. " Refer to F610 POC. " Residents were not affected by the deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Facility wide education completed on reporting alleged violations putting emphasis on timing, reporting within 2 hours of allegation to appropriate agencies, investigating injuries of unknown origin, and any allegation of abuse. " Grievances, Incidents, and abused allegations will be reviewed daily in morning meetings. " Refer to F610 POC. IV. MONITORING OF CORRECTIVE ACTIONS: " Administrator or Designee will audit 6 Grievances, Incidents, and Reportable weekly for 4 weeks and 6 Grievances, Incidents, Reportable Monthly x2 to ensure reporting took place within 2 hours of	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 609	Continued From page 25 Resident #42 talking in a [NJ Ex Order 26.4(b)(1)] in the hallway about the [NJ Exec Order 26.4b1]. When Resident #85 was asked why did not report the incident sooner, resident stated it had been on resident's mind to report it but he/she did not. Resident #42 explained maybe [NJ Exec O] nights before, around midnight, a male went into his/her room, led the resident to [NJ Ex Order 26.4(b)(1)] and while in the [NJ Exec Order 26.4b1] the aide [NJ Exec Order 26.4b1]]. On 5/28/24 at 01:06 PM, the [U.S. FOIA (b)(6)]) provided S#1 with and Abuse Investigation and Reporting Policy. On 5/30/24 at 10:30 AM, the facility met with the survey team and did not provided any additional information regarding the delay in reporting for the [NJ Ex Order 26.4(b)(1)] of [NJ Exec Order 26.4b1] 2. On 5/23/24 at 9:32 AM, S#2 received information from S#3 that Resident #104 reported to S#3 that he/she was [NJ Ex] by a staff about a [NJ Exec O] ago. On 5/23/24 at 9:35 AM, during a meeting with the [U.S. FOIA (b)(6)] S#2 discussed the information received by the surveyor regarding Resident #104's [NJ Ex Order 26.4(b)(1)] that a staff had [NJ Ex] the resident. At that time, the [U.S. FOIA (b)(6)] stated, "We will start the investigation right now." At that time, the [U.S. FOIA (b)] stated, "We will report to the state agency and the [NJ Ex Order 26.4(b)(1)] According to the Admission Record (AR, an	F 609	allegation to appropriate agencies, proper investigation of injuries of unknown origin, and any allegation of abuse is reported to DOH. " Audit Findings will be reported to the monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement.) Committee will determine the need for further audits and/or action plans. " Refer to F610 POC.	

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F 609	Continued From page 26	F 609		

admission summary) Resident #104 had diagnoses which included, but were not limited to, NJ Exec Order 26.4b1 [redacted]

A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated U.S. FOIA (b)(6), included the resident had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1 which indicated the resident's cognition was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 It included that the resident had no signs or symptoms of NJ Exec Order 26.4b

The resident's individualized care plan reflected a focus that the resident had an NJ Ex Order 26.4(b)(1) [redacted], initiated on NJ Ex Order 26.4(b)(1) ...The interventions included NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) [redacted]. Additionally, the resident required NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) [redacted] and for changes to be reported to the nurse.

A review of Resident #104's NJ Ex Order 26.4(b)(1) revealed the following:
-On NJ Ex Order 26.4(b), NJ Exec Order 26.4b1 [redacted]
-On NJ Ex Order 26.4(b), NJ Exec Order 26.4b1 [redacted]
-On NJ Ex Order 26.4(b Exec Order 26.4b1 [redacted]
-On NJ Ex Order 26.4(b), NJ Exec Order 26.4b1 [redacted]
-On NJ Ex Order 26.4(b), NJ Exec Order 26.4b1 [redacted]
-On NJ Ex Order 26.4(b), [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 609		F 609		

Continued From page 27

-On [redacted], NJ Exec Order 26.4b1
-On [redacted], NJ Exec Order 26.4b1

A review of the facility provided Investigation Summary and Conclusion reflected the [redacted] interviewed the resident, a resident statement made to the [redacted] and "a [redacted] assessment was conducted with no findings."

The Witness Statements revealed the following:

-Review of the statement from the [redacted] dated [redacted], reflected that the resident reported to the [redacted] that a NJ Exec Order 26.4b1] male registered nurse [redacted] the resident's NJ Exec Order 26.4b1 in the [redacted]

-Review of the statement from the Registered Nurse dated [redacted] at 9:45 AM, reflected that the resident stated he/she was [redacted] The resident was noted to be [redacted] NJ Exec Order 26.4b1 and [redacted] no apparent [redacted] was able to [redacted] with no [redacted] "A [redacted] noted to NJ Exec Order 26.4b1."

-Review of the statement from the [redacted] dated [redacted] reflected that when she had entered the room the NJ Ex Order 26.4(b)(1) was in progress. The resident stated to the [redacted] that he/she [redacted] by a NJ Exec Order 26.4b1] while walking in resident's room and the incident occurred in NJ Ex Order 26.4(b)(1). The [redacted] documentation also reflected that the responsible party (RP) of the resident did not believe the incident was true.

On 5/29/24 at 12:52 PM, in the presence of the survey team, the U.S. FOIA (b) (6) [redacted] and

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 609	Continued From page 28	F 609		

the [U.S. FOIA (b)] S#2 discussed the concern regarding the facility's [NJ Ex Order 26] investigation process for Resident #104's [NJ Exec Order] of NJ Ex Order 26.4(b)(1). There was no evidence provided that the facility reported to the State Agency within the two (2) hour time frame upon discovery.

On 5/30/24 at 9:41 AM, in the presence of S#2, and the U.S. FOIA (b)(6) stated that the [NJ Ex Order 26.4(b)(1)] of NJ Ex Order 26.4(b)(1) was reported to the State Agency and the U.S. FOIA (b) (6)

At that time, the [U.S. FOIA (b)] submitted a copy of the RER that indicated the event was called in on [NJ Ex Order 26.4(b)] at 10:00 AM and was reported as a [NJ Exec O] [NJ Exec Order 26]

Further review of the RER reflected the resident [NJ Ex Order 26.4(] that the resident was [NJ Ex] by a nurse and could not identify the nurse. The resident stated it might have been a [NJ Exec Order 26.4b1] male. The incident occurred in the [NJ Ex Order 26.4(b)(1)] while in the chair, then while walking and that the incident occurred in [NJ Exec Orde]

At that time, the [U.S. FOIA (b)(6)] stated that the [NJ Exec Order 26.4b1] was unsubstantiated for the NJ Exec Order 26.4b1 [ ] since there were no NJ Exec Order 26.4b1] male nurses.

At that same time, S#2 asked the [U.S. FOIA (b)] if there were any other information associated with Resident #104's NJ Exec Order 26.4b1 noted to NJ Exec Order 26.4b1." The [U.S. FOIA (b)] stated that the staff to resident [NJ Exec Order] was unsubstantiated, while the investigation for the NJ Exec Order 26.4b1 continued. The incidents were delineated which was the reason it was not mentioned in the summary and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 609	Continued From page 29 conclusion provided. On 5/30/24 at 12:02 PM, in the presence of the survey team, the U.S. FOIA (b)(6) stated that the resident had narrated three (3) different stories. The U.S. FOIA (b) stated she had unsubstantiated the part of that a man had NJ Exec Order 26 the resident and was still investigating the NJ Exec Order 2 on the resident's U.S. FOIA (b)(6). At that time, the U.S. FOIA (b) provided three additional statements that were related to the NJ Exec Order 26.4 investigation. The U.S. FOIA (b) confirmed the investigation for the NJ Exec Order 26 had not concluded. On 5/31/24 at 9:54 AM, in the presence of the survey team, the surveyor gave the U.S. FOIA (b)(6) an opportunity to submit additional information. No additional information was provided. 3. On 5/23/24 at 10:13 AM, S#4 observed Resident #35 NJ Exec Order 26.4b1 in their wheelchair with his/her head NJ Exec Order 26.4b1 with a NJ Exec Orde. A review of the resident's most recent quarterly MDS dated NJ Exec Order 26.4 reflected that the resident had a BIMS score of NJ Exec Order 26.4b1 indicating NJ Exec Orde A review of the Grievance/Complaint Investigation Report dated NJ Exec Order 26.4 revealed Resident #35 filed a grievance with the U.S. FOIA (b)(6)). The section referencing to documentation of grievance/complaint, documentation of facility follow up and resolution of grievance/complaint read as followed:	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 609	Continued From page 30 -Describe concern briefly using factual terms: (attach resident/family concern form)? "The resident reported he/she was removed from the NJ Exec Order 26.4b1 group meeting by the U.S. FOIA (b) (6) [redacted] when she asked to postpone the meeting when other departments could be present. Resident did not appreciate being spoken to in the matter he/she was." -What other action to resolve concern (be specific)? "The U.S. FO was asked to be mindful of her tone of voice with the residents, as she may come as speaking to loudly and to utilize an approach to gently guide the resident(s) to another aspect or task within the current activity without making them feel interrupted or excluded." -Was the grievance/complaint resolved? Yes, "the U.S. FOIA (b)(6) [redacted] informed the resident that the staff member was addressed regarding her approach with the resident. The resident was justified with the resolution." On 5/24/24 at 10:29 AM, S#4 interviewed the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA stated [he/she] recalled an incident that happened on the second floor of the facility in the activity room/dining area. The U.S. FOIA stated the resident was seated in wheelchair and the U.S. FO NJ Ex Order 26.4(b)(1) the resident away from the table. The U.S. FO said it was on camera and the resident filed a complaint. The U.S. FO stated that was the last time [he/she] had seen the U.S. FOIA On 5/28/24 at 11:29 AM, S#4 interviewed Resident #35 who stated the U.S. FO was loud and inappropriate in her approach. Resident #35 stated that the U.S. FO wanted [him/her] to leave the	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 609	Continued From page 31	F 609		

room and the resident was not ready to. Resident #35 stated, "[redacted] " The resident stated [he/she] reported it to administration and there were other people present but can not remember who was there.

On 5/29/24 at 10:00 AM, S#4 interviewed the [redacted] in the presence of the survey team and the [redacted] stated the [redacted] was [redacted] shortly after, and the facility had no other statements to provide. The [redacted] stated the facility does not have video footage of the incident and the surveillance was only kept for 24-48 hours.

On 5/29/24 at 11:04 AM, the surveyor interviewed the [redacted] and stated the [redacted] choose to [redacted] after the incident and the [redacted] came and did an investigation. The [redacted] stated there was "nothing to be reported" to the DOH.

A review of the provided facility policy dated 5/01/24 included the following:
Reporting:
2. 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 (2) hours if the alleged violation involves abuse or has resulted in serious bodily injury; or
-Twenty-four (24) hours if the alleged violation dies not involve abuse AND has not resulted in serious bodily injury.
5. The Administrator, or his/her designee will provide the appropriate agencies or individuals listed above with a written report of the finding of the investigation within five (5) working days of the occurrence of the incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 609	Continued From page 32	F 609		
F 610 SS=F	NJAC 8:39-9.4 (f) 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 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: Complaint #NJ164582, NJ169759, and NJ171307 Based on observations, interviews, record review and review of other facility pertinent documents, it was determined the the facility failed to complete and document a thorough investigation: a) to determine the origin for [redacted] to a resident's (Resident #6) [redacted] b) after receiving an [redacted] of two residents who were [redacted] by a staff member (Resident #42 and Resident #85), and c) an [redacted] of [redacted] (Resident #35). This deficient practice was	F 610	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " A thorough investigation was conducted to determine the origin of [redacted] for resident #6. " Reviewed investigation for resident #35, #42, and #85 " Resident #6 o Will be informed of any procedure or [redacted] to be completed.	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 33 identified for four (4) of four (4) residents reviewed for [redacted] and evidenced by the following: 1. On 5/21/24 at 10:15 AM, the surveyor observed Resident #6 in bed. The resident informed the surveyor that resident NJ Ex Order 26.4(b)(1) that he/she would like to discuss after breakfast. On that same date at 11:05 AM, the surveyor returned to Resident #6's room. The resident explained to the surveyor that he/she had some [redacted] to the NJ Exec Order 26.4b1 that the resident obtained during NJ Exec Order 26.4b1. The resident stated that the U.S. FOIA (b) (6) had Certified Nursing Assistant #1 (CNA#1) holding the resident's down for NJ Exec Order 26.4b1 on [redacted] Resident #6 further stated that he/she attempted to explain that he/she had NJ Exec Order 26.4b1 on [redacted] and would like to know why NJ Exec Order 26.4b1 had to be [redacted] again the morning of [redacted] Instead of providing the rationale for the [redacted], the NJ Exec Order 26.4b1 ordered the CNA to hold the resident down for the NJ Exec Order 26.4b1. Furthermore, the resident stated that the Registered Nurse (RN) on duty that day heard them NJ Exec Order 26.4b1 and was mad at them for NJ Exec Order 26.4b1 The RN did not explain why [redacted] had be [redacted] this morning again on U.S. FOIA (b)(6) Resident #6 stated that he/she was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, and the resident reported the incident. Resident #6 further stated that the resident had been on NJ Exec Order 26.4b1 [redacted] and never had this issue before. The surveyor reviewed the medical record of Resident #6.	F 610	o will be educated on the reason/need for procedure. o Seen by NJ Ex Order 26.4(b)(1) o A team member will accompany the vendor into the room for any lab work/procedure. o Resident to be visited by Director of Social Services for NJ Ex Order 26.4(b)(1). " Resident #85 o A personalized care plan was implemented for at risk for NJ Ex Order 26.4(b)(1) NJ Exec Order 26.4b1 related to an allegation of NJ Exec Order 26.4b1. o NJ Ex Order 26.4(b)(1) provided through social worker visits. o NJ Ex Order 26.4(b)(1) consults in place to address NJ Exec Order 26.4b1 needs. o On-going NJ Ex Order 26.4(b)(1) consult, NJ Exec Order 26.4b1. " Resident #42 o A personalized care plan was implemented for at risk for NJ Ex Order 26.4(b)(1) well-being related to an NJ Ex Order 26.4(b)(1). o NJ Ex Order 26.4(b)(1) provided through social worker visits. o NJ Ex Order 26.4(b)(1) consults in place to address NJ Exec Order 26.4b1 needs. o On-going NJ Exec Order 26.4b1 consult, NJ Exec Order 26.4b1. " Facility wide education includes vendors completed on investigating, preventing, and correcting alleged violations putting emphasis on investigating injuries of unknown origin, collecting statements, Interventions, and assessment documentation. " Residents were not adversely affected	

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F 610	Continued From page 34 The Admission Record (AR, or face sheet, an admission summary) indicated that Resident #6 was admitted to the facility with diagnoses which included, but were not limited to NJ Exec Order 26.4b1 [redacted] The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Exec Order 26.4b1 revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) score U.S. FOIA (b)(6) indicative of NJ Exec Order 26.4b1 [redacted]. The MDS of the resident showed that the resident was able to make his/her needs known. The comprehensive Care Plan (CP) with a Focus for NJ Ex Order 26.4(b)(1) [redacted] was initiated on NJ Exec Order 26.4b1 The CP did not have a Focus which indicated that the resident was NJ Exec Order 26.4b1 with care and staff needed to NJ Exec Order 26.4b1 [redacted] for NJ Exec Order 26.4b1 A review of the nurses's progress notes (PN) dated U.S. FOIA (b)(6) The RN documented: NJ Exec Order 26.4b1 [redacted] of the resident. NJ Exec Order 26.4b1 : NJ Exec Order 26.4b1 [redacted]. No changes in NJ Ex Order 26.4(b)(1)). Resident said," It probably happen during NJ Exec Order 26.4b1 yesterday referring to NJ Exec Order 26.4 and a NJ Exec Orde was assisting to NJ Exec Order 26.4 the NJ Exec Orde NJ Exec Order 26.4b1 [redacted]) made aware." On 5/21/24 at 11:50 AM, the surveyor interviewed the RN who wrote the progress note dated NJ Exec Order 26.4. The nurse confirmed that he noted the	F 610	by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the same deficient practice. " Residents were not affected by the deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Facility wide education completed on investigating, preventing, and correcting alleged violations putting emphasis on investigating injuries of unknown origin, collecting statements, Interventions, and assessment documentation. " Statements will be obtained from all staff/vendors involved in any allegation of abuse. " The administrator or designee will review all allegations of abuse for completion putting emphasis on statement collection, assessment documentation, and interventions. IV. MONITORING OF CORRECTIVE ACTIONS: " Administrator or Designee will audit all Reportable weekly for 4 weeks and all reportable Monthly	

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F 610	Continued From page 35 NJ Exec Order 26,took pictures, NJ Exec Order 26.4b1 and generated the incident report. The RN stated that the incident was reported to the administrative staff. On 5/23/24 at 11:14 AM, during an interview with the CNA involved with the incident, she revealed that Resident#6 gets NJ Exec Order 26.4b1 at times but was not NJ Exec Order 26.4b1 with care. On 5/23/24 at 11:30 AM, the surveyor requested the investigation for review. On 5/23/24 at 12:50 PM, in the presence of the survey team, the U.S. FOIA (b)(6)) provided the incident/accident (I/A) report dated NJ Exec Order 26.4 and stated that all she had. The U.S. FOIA (b)(6 added that she knew what had happened, the resident was NJ Ex Ord and able to explain that the NJ Exec Order 26 were obtained during NJ Exec Order 26.4b1 The NJ Exec Orde stated that she did not have an investigation. There were no employee statements from the prior three shifts included in the incident report provided. The I/A report included the CNA statement who worked and reported the NJ Exec Order 26.4b1 There were no written statements obtained from the the day shift staff involved with Resident #6's care. Attached to the I/A Report was a form titled, " NJ Ex Order 26.4(b)(1) Investigation," dated NJ Exec Order 26.4 completed by the RN. Under the steps to follow, the following were documented under step #:5- Assess age of NJ Ex Order 26.4(b)(1). NJ Exec Order 26.4b1 ? NJ Exec Order 26.4b1 ? NJ Exec Order 26.4b1 ? NJ Exec Order 26.4b1 the RN documented, " NJ Exec Order 26.4b1 7 What does the resident say about how	F 610	x2 to ensure proper investigation, prevention, and correction of alleged violation. " Audit Findings will be reported to the monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement.) The committee will determine the need for further audits and/or action plans.	

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F 610	Continued From page 36	F 610		

the I/A occurred? Said it happened when CNA#1 also assisted during NJ Exec Order 26.4b1 the previous day NJ Exec Order 26.4b1)

CNA#2 who worked the 3:00 PM-11:00 PM shift, documented, " I notice the NJ Exec Order 26.4b1 when I transfer the resident to bed and changed the clothing. I notified the nurse."

The Interdisciplinary Notes attached to the I/A report indicated the following: "Resident #6 was noted to have NJ Exec Order 26.4b1 . Resident #6 had NJ Exec . NJ Exec Order 26.4b1 , and the area will be monitored. Resident #6 is questioning frequent NJ Exec Order 26.4b1 will review with physician and NP. Will monitor for NJ Exec Order 26.4b1 Educate technician. Resident #6 is on NJ Exec Order 26 . Resident #6 states that their NJ Exec O was NJ Exec Order 26.4b1 while the NJ Exec was being NJ Exec Order 26 The NJ Exec O of the NJ Exec Order 26.4b1 could be seen on NJ Exec Order 26.4b1 ."

On 5/28/24 at 12:52 PM, CNA#1 was interviewed again with another surveyor. She stated that she was already in the room assisted another resident when she heard the exchange between the U.S. FOIA and the resident. The resident did not want the NJ Exec Order 26.4b1 , she came and stood at the bedside and Resident #6 NJ Exec Order 26.4b1 . The CNA denied that she held the resident's NJ Exec Orde for the NJ Exec Order 26.4b1 .

On 5/28/24 at 02:30 PM, the U.S. FOIA (b)(6) provided the investigation summary. According to the interview, Resident #6 told the U.S. FOIA (b) both CNA#1 and the NJ Exec Order 26.4b1 held their NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1

A telephone statement obtained from the U.S. FO

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F 610	Continued From page 37	F 610		

U.S. FOIA (b) (6) dated NJ Exec Order 26.4 indicated, " "Resident #6 did not like having the NJ Exec Order 26.4b1. Resident got NJ Exec Order 26.4b1 that day and wanted to NJ Exec Order 26. Resident #6 NJ Exec Order 26.4b and since CNA#1 was there, I asked the CNA to help."

On 5/29/24 at 8:44 AM, the surveyor interviewed the RN in charge of Resident #6's care. The RN stated that she was at the desk when she heard the NJ Exec Order 26.4b1, she went to the room and the NJ Exec Order 26.4b1 was already in process, she remained in the room until the NJ Ex Order 26.4(b)(was completed. She confirmed that the resident was not informed of the NJ Exec Order 26.4b1 for NJ Exec Order 26.4 nor made aware of the NJ Ex result of NJ Exec Order 26.4b1

On 5/29/24 at 9:15 AM, the surveyor interviewed the U.S. FOIA (b)(6)) in charge of Resident #6's care. The U.S. FOIA (b)(6 stated that she was not made aware of the NJ Ex Order 26.4(b)(being done for NJ Exec Order 26.4b1. The U.S. FOIA (b was made aware of the NJ Exec Order 26 on NJ Exec Order 26.4 and spoke with the nurse, who stated that the NJ Exec Order 26 were obtained during NJ Exec Order 26.4b1.

On 5/29/24 at 9:24 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated that she spoke with the resident during the Quarterly meeting on NJ Exec Order 26.4 and the resident expressed some concerns with recent NJ Ex being NJ Exec Order 2 The resident reported NJ Exec Order 26.4b on NJ Exec Ord with recent NJ Ex Order 26.4(b)(. When I observed the NJ Exec Order 26.4b1, it was already NJ Exec Order 2

On that same date and time, the NJ Exec Orde informed the surveyor that on NJ Exec Order 26.4 she discussed the issue with the U.S. FOIA (b)(6 The U.S. FOIA (b) went on to state that the resident stated in the presence of the

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F 610		F 610		

Continued From page 38

NJ Exec Order 26.4b1 that " I am NJ Exec Order 26.4b1 about the recent NJ Exec Order 26.4b1, I got NJ Exec Order 26.4b1 a few days ago (NJ Exec Order 26.4b1) someone showed again for NJ Exec Order 26.4b1 I said "No" I wanted the NJ Exec Orde from the previous NJ Exec Order 26.4b1 The NJ Ex Order 26.4(b)(1) asked the CNA to NJ Exec Order 26.4b for the NJ Exec Order 26.4b1, it was very NJ Exec Order 26.4b1

On 5/29/24 at 10:36 AM, the surveyor interviewed the physician regarding the NJ Ex Order 26.4(b)(done on NJ Exec Order 26.4b1. The physician informed the surveyor that he was not aware of the NJ Ex Order 26.4(b)(1 He reviewed the NJ Ex Order 26.4(b)(today NJ Exec Order 26.4. He further stated that his expectation was that he would be notified of any NJ Exec Order 26.4b1.

2. The surveyor reviewed a Reportable Event Record (RER) that had been submitted to the Department of Health (DOH) by the facility NJ Exec Orde on NJ Ex Order 26.4(b)(at 12:34 PM revealed:

Today's date: NJ Ex Order 26.4(b)(1
Date of Event: NJ Ex Order 26.4(b)(1
Time of Event: 6:30 PM
Was this a significant event? "Yes".
Type of Incident: NJ Ex Order 26.4(b)(1) NJ Exec Order 26
Narrative: Resident #85 stated NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 who got the resident ready for bed on Saturday evening NJ Ex Order 26.4(b)(. Resident #85 stated heard Resident #42, speaking in a NJ Exec Order 26.4b1" and stated the 'NJ Exec Order 26.4b1" and that's why he/she reported this issue today NJ Exec Order 26.4b . Resident #42, upon interview [untimed] stated that during care a few days ago, a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 entered the room, took the resident NJ Ex and NJ Ex Order 26.4(b)(1) on NJ Exec Order 26

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F 610	Continued From page 39	F 610		

2. Prior to the event, was a plan of care developed that addressed this issue: "No."

3. What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions:
-Both residents were interviewed and NJ Exec Order 26.4b1 were completed immediately NJ Ex Order 26.4(b)(1).
-Staff identified and was send home immediately.
-Family and physicians were notified.
-NJ Ex Order 26.4(b)(1) was notified. Investigation on going.

The undated Investigation Summary submitted by the facility revealed:
Investigation:
On NJ Ex Order 26.4(b)(1), Resident #85 reported to the nurse on duty, that the resident did not like the way the U.S. FOIA (b)(6) who provided care on Saturday evening and NJ Exec Order 26.4 resident's U.S. FOIA (b)(6) The nurse informed the U.S. FOIA (b) who went to further interview Resident #85. Resident #85 stated that on U.S. FOIA (b)(6) the aide was NJ Exec Order 26.4b his/her NJ Exec Order 26.4b1 NJ Exec Order 26.4b1."

Resident #85 stated that on NJ Ex Order 26.4(b)(1), heard Resident #42 talking in a [NJ Exec Order 26.4b1] in the hallway about the NJ Exec Order 26.4b1 When Resident #85 was asked why did not report the incident sooner, resident stated it had been on resident's mind to report it but he/she did not.

U.S. FOIA (b) and a NJ Exec Order 26.4b1 speaking staff interviewed Resident #42.

Resident #42 explained maybe two nights before,

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F 610	Continued From page 40	F 610		

around midnight, a NJ Exec Order 26.4b1 [redacted]

Resident #42 stated that he/she told his/her family member (FM). About the incident who told the resident to NJ Exec Order 26 and NJ Exec Order 26.4b1 about it.

The U.S. FOIA (b) placed a call to the FM and asked why the FM did not report the incident. "I did not know what to make of it, my NJ Exec Order 26 is [redacted] and has [redacted] about [redacted] being in the NJ Exec Order 26.4 and I thought that is what was NJ Exec Order 26.4b1 him/her, [redacted] is very [redacted] and does NJ Exe [redacted] for him/her"

The involved CNA#3 was interviewed and denied the accusation. CNA#3 stated he was assisting Resident #42 to the NJ Exec Orde when the FM arrived at the floor, the CNA left when FM entered the room.

Both residents were interviewed by the NJ Ex Order 26.4

The roommate of Resident # 85 was present in the room during all interactions and denied seeing or hearing any incidents.

Both Residents had complete NJ Ex Ord assessment and NJ Ex Order 26.4(b)(1) noted.

Summary/Conclusion:
-The NJ Ex Order 26.4(b)(1) was Unsubstantiated.
-According to the staff, Resident #42's FM visited right when CNA#3 was with Resident #42 and entered the room before the CNA left.
-CNA#3 stated he only assisted the resident at that time before his/her FM visited and that the FM met the CNA in NJ Ex Order 26.4(b)(1) with the

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F 610	Continued From page 41 resident when he was sitting Resident #42 [redacted] and left the resident in the care of the FM. - "All alert and oriented patients" on the unit who were cared for by the employee were interviewed and did not report any concerns. Interventions: -Both Residents #42 and #85 were educated on reporting incidents immediately. -FM was educated on reporting incidents regardless of the residents' [redacted] or description of the incident. -Both residents were assessed, [redacted] assessment was done with no [redacted] noted. -Both residents were referred for [redacted] consult for [redacted]. -Incident reported to the [redacted] -The employee was an [redacted] staff; he was suspended immediately pending the investigation and will not return. On 5/23/24 at 10:30 AM, the surveyor reviewed the electronic Medical Record (eMR) for both residents to determine compliance with the investigation submitted by the [redacted] Resident #85's AR revealed diagnoses which included, but were not limited to; [redacted] A review of the 22-page current CP with a target date of [redacted] and including resolved items, did not reveal a Focus related to the [redacted] of [redacted] that occurred on [redacted] and was reported on [redacted]	F 610		

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F 610	Continued From page 42	F 610		

A review of the multi-disciplinary PN from NJ Exec Order 26.4b1 did not reveal a nurses note or physician documentation related to the NJ Ex Order 26.4(b)(1) of NJ Exec Order 26.4b1 that occurred on NJ Ex Order 26.4(b)(1) and was reported on NJ Ex Order 26.4(b)(1). A physical NJ Exec Order 26.4b1 or any other type of assessment related to the NJ Ex Order 26.4(b)(1) of NJ Exec Order 26 was not located in the eMR or paper medical record. There was no assessment and NJ Exec Order 26.4b1 assessment completed and documented as per the facility documented interventions. There was no NJ Ex Order 26.4(b)(1) consult for NJ Ex Order 26.4(b)(1) documented in the medical record and as per the facility documented interventions.

The most recent Annual MDS of Resident #85 indicated a BIMS score of U.S. FOIA (b)(6) that showed resident was NJ Exec Order 26.4b1.

On 5/28/24 at 8:20 AM, the surveyor conducted an interview with Resident #85 while the resident was in the room eating breakfast. The surveyor asked the resident about any concerns that occurred with any staff. Resident #85 stated, a CNA NJ Exec Order 26.4b him/her in the NJ Exec Order 26.4b1 and stated the CNA did it when he was getting Resident #85 ready for bed.

Furthermore, Resident #85 stated the same day a few hours later, the resident overheard Resident #42 stating the same CNA NJ Exec Order 26.4b Resident #42 NJ Exec Order 26.4b him/her NJ Exec Order 26.4b1 and Resident #85 reported it 1-2 days later. Resident #85 confirmed the NJ Ex Order 26 came and interviewed Resident #85. When asked about the roommate being present at the time, Resident #85 stated the curtain was drawn.

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F 610	Continued From page 43 On 5/28/24 at 8:53 AM, the surveyor requested, from the[US FOIA (b) (6)] and the[US FOIA (b) (6)] the investigations related to Resident #42 and Resident #85's[NJ Ex Order 26.4(b)(1)] and specifically requested the documents in their entirety, including any statements and any documents utilized to complete the investigation and completed because of the investigation. On 5/28/24 at 9:20 AM, the[NJ Exec Order 26.4] provided the surveyor with, what he confirmed, was the completed facility investigation. The surveyor initially reviewed the documents which included one document titled "Witness Statement" from the accused CNA#3, and a type written undated document. The surveyor again requested all documents from the[U.S. FOIA (b)], in the presence of the[U.S. FOIA (b)(6)] regarding statements and any investigative documents that were reviewed to determine the conclusion of the investigation. The[U.S. FOIA (b)] pointed to her type-written summary and stated, "those were the statements." On 5/28/24 at 9:35 AM the[U.S. FOIA (b)] in the presence of the survey team, stated that the two documents provided, one titled "Witness Statement" and the other untitled document were the only separate statements as part of the investigation. The surveyor asked why the typed statement was not dated and she stated, "it was a mistake." The surveyor requested the information when the accused CNA#3 worked and requested the time punch logs. The surveyor asked the[U.S. FOIA (b)] about any assessments that were completed as alleged and the[U.S. FOIA (b)] stated, that "usually when we do a regular body assessment, we put a note in the [eMR]."	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 610	Continued From page 44 At that time, the surveyor notified the [redacted] that there were no documented assessments in the eMR and she did not provide any assessments for any other residents that may have been affected or the [redacted]. The [redacted] stated, "if it is not there, then I did not do it." The surveyor asked the [redacted] when the accused CNA#3 provided a statement, and the [redacted] stated he was asked to come in to only fill out a statement and she will look for additional documents related to the investigation. A further review of the facility provided investigation revealed the following documents: -A copy of a [redacted] card (there were no [redacted] included in the investigation). The surveyor requested a copy of the [redacted] from the [redacted] as the facility confirmed they never requested the reports. - The RER - A handwritten "Witness Statement" Date of Incident: [Left Blank]; Time of Incident: [Left Blank]; Date and Shift of Witness Involvement: 7-3; Job Title: CNA#3; Please describe what happened in detail: "The bed alarm went off for [Resident #42's room] so I went to check since [CNA #4] was with another resident. I took [him/her] to [redacted] when [he/she] asked me when I arrived to [his/her] room. The FM came [redacted] while I was [redacted] the resident [redacted] I then left and the FM was going to help [Resident #42] afterwards. [Resident #42] then came a couple of hours later exclaiming [redacted] [him/her]. I informed nurse and the family when they came back. Signed by CNA#3, Date Completed: [redacted]. - A type written document, undated and signed by [CNA #4] revealed: "I was assigned to Resident #42 for the shift; while I was assisting another	F 610		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 610	Continued From page 45 patient (also known as resident) next door, the other CNA came to me to tell me that Resident #42 needed help. I asked him to go help the resident as I was busy. When I came out of the other patient's room, I saw the FM of Resident #42 in the hallway and he/she asked me where Resident #42 was and I told FM they took him/her to the bathroom; the FM opened the [NJ Ex Order 26.4(b)(1)] door to check on the resident and I saw CNA#3 leaving the room. After a while, the FM left, Resident #42 was saying [NJ Exec Order 26.4b1]," but when I asked [him/her] what happened [he/she] did not say anything. I helped the nurse take Resident #42 back to their room. The document was signed and undated. There was no documented statement from Resident #42 or the roommate, Resident #85, the FM, nurse, or any other staff or residents who may have been a witness. The Investigation Summary: On [NJ Ex Order 26.4(b)(1)], Resident #85 reported to the nurse on duty, that he/she did not like the way the [NJ Ex Order 26.4(b)(1)] who provided care on Saturday evening and [NJ Ex Order 26.4(b)(1)] his/her [NJ Exec Order 26.4b1]. The nurse informed the [U.S. FOIA (b)] who went to further interview Resident #85. Resident #85 stated that on [NJ Ex Order 26.4(b)(1)] CNA#3 approached him/her and asked if the resident was ready to be [NJ Ex Order 26.4(b)(1)]. Resident #85 stated that CNA#3 [NJ Ex Order 26.4(b)(1)], felt was [NJ Exec Order 26.4b1] his/her [NJ Exec Order 26.4b1] No documented statements from the nurse on duty or the [U.S. FOIA (b)] were included and no statements were obtained from any other staff or residents cared by CNA#3 .	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 610	Continued From page 46	F 610		

Resident #85 stated that on [NJ Ex Order 26.4(b)(1)], heard Resident #42 talking in a [NJ Exec Order 26.4b1] in the hallway about the [NJ Exec Order 26.4b1]." When Resident #85 was asked why did not report the incident sooner, resident stated it had been on resident's mind to report it but he/she did not.

[NJ Exec Orde] and a [NJ Exec Order 26.4b1] speaking staff interviewed Resident #42. There was no statement included in the investigation from the [NJ Exec Order 26.4b1] staff.

Resident #42 explained maybe two nights before, around midnight, a [NJ Exec Orde] went into resident's room, [NJ Exec Order 26.4b1] led the resident [NJ Ex Order 26.4(b)(1)] and while in the [NJ Exec Order 26.4b1], the aide put [NJ Exec Order 26.4b1] There were no additional details included in the description as to what was provided to the DOH, and there were no documented statements from Resident #42. When the [NJ Exec Orde] asked Resident #42 what the resident did about it and why the resident did not report it. Resident #42 stated he/she [NJ Exec Order 26] CNA#3 [NJ Exec Order 26.4b1] and told the FM who then told him/her to[NJ Exec Order 26.4b1] about it.

There was no additional information added from the DOH submission and no documented statements included.

The [NJ Exec Orde] placed a call to the FM.

The FM explained that visited Resident #42 multiple times that day and spoke to Resident #42 who then told the FM what happened.

The [U.S. FOIA (b)] placed a call to the FM and asked why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 610	Continued From page 47	F 610		

the FM did not report the incident. "I did not know what to make of it, my [NJ Exec Order 26.4b1] is [NJ Exec Order 26.4b1] and has been [NJ Exec Order 2] about [U.S. FOIA (b)(6)] being in the [NJ Exec Order 26.4] and I thought that is what was bothering him/her, [U.S. FOIA (b)(6)] is very [NJ Exec Order 2] and does [NJ Exec] for him/her."

[U.S. FOIA (b)] educated FM to immediately report any incidents.

The involved CNA#3 was interviewed and denied the accusation. CNA#3 stated he was assisting Resident #42 to the [NJ Exec Or] when the FM arrived at the floor, the CNA left when FM entered the room. The documented "Witness Statement" from the CNA differs from this account and from CNA #4's documented statement and was not further investigated.

CNA #4, the assigned CNA stated that the FM spent some time with Resident #42, then left with no issues. CNA #4 stated that sometime later after the FM left, she saw Resident #42 in the hallway upset saying [NJ Exec Order 26.4b1]" but was redirected back to resident's room.

A Nurse on duty stated that the FM visited multiple times during the shift. She stated that nothing was reported to her at that time and the FM left. There was no statement included from the nurse in the investigation.

Both residents were interviewed by the police department:
Resident #85 reported to the [NJ Ex Order 26.] in the presence of the [U.S. FOIA (b)], that felt as if "[NJ Ex Order 26.4(b] " Resident #85 told the [NJ Exec Order] that reported the incident because Resident #42 said the same thing in a NJ Exec Order 26.4b1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 610	Continued From page 48 Resident #42 repeated the same thing he told the [redacted] to the [redacted] The roommate of Resident # 85 was present in the room during all interactions and denied seeing or hearing any incidents. Both Residents had complete [redacted] assessment and [redacted] noted. Summary/Conclusion: (Differed from the original that indicated the [redacted] were unsubstantiated.) The facility could not conclude whether the nursing assistant NJ Exec Order 26.4b1 Resident #42's [redacted], or whether CNA#3 NJ Exec Order 26.4b1 [redacted] Resident #85. According to the staff, the FM visited right when the nursing assistant was with the resident and entered the room before the staff left. CNA#3 stated that he only assisted the patient at that time before the FM visited and that the FM met him/her right when he/she was [redacted] him/her NJ Exec Order 26.4b1; and that he left the patient in the care of the FM. The resident's FM stated that Resident #42 did not tell him/her about the incident when visiting and NJ Ex Order 26.4(b)(1) , until the FM came back later about 8-8:30 PM. All alert and oriented residents on the unit who were care for by the employee were interviewed and did not report any concern with regards to him rendering care.	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 610	Continued From page 49	F 610		

On 5/28/24 at 10:04 AM, the surveyor asked the [U.S. FOIA (b)] who was looking through documents in her office, about any additional investigation documents including statements and the [U.S. FOIA (b)] stated she will continue to look and asked Human Resources for the punch in and out logs for CNA#3. The [U.S. FOIA (b)] stated, if she did not have anything else she would let the surveyor know.

On 5/28/24 at 10:21 AM, the [NJ Exec Ord] stated she cannot locate any other documents.

On 5/28/24 at 10:30 AM, the [U.S. FOIA (b)(6)] provided the dates CNA#3 worked at the facility which included the following dates and punch in and out times:
1. [NJ Ex Order 26.4(b)(1)] - 7:26 AM-3:09 PM
2. [NJ Ex Order 26.4(b)(1)] - 3:09 PM-10:55 PM
3. [NJ Ex Order 26.4(b)(1)] - 3:10 PM-10:51 PM
4. [NJ Ex Order 26.4(b)(1)] - 7:13 AM-3:00 PM
5. [NJ Ex Order 26.4(b)(1)] -3:00 PM -10 (area x)
6. [NJ Ex Order 26.4(b)(1)] -8:38 AM-3:11 PM
7. [NJ Ex Order 26.4(b)(1)] - 3:13 PM-10:41 PM
8. [NJ Ex Order 26.4(b)(1)] - 8:42 AM-3:02 PM

On 5/28/24 at 11:10 AM, the surveyor interviewed the U.S. FOIA (b)(6) who stated she had been at the facility for NJ Ex Order 26.4(b)(1). She stated she was the U.S. FOIA (b)(6). The surveyor asked what the protocol for abuse was. She stated if she received an NJ Ex Order 26.4(b)(1), she would inform the [U.S. FOIA (b)(6)] and [U.S. FOIA (b)]. She stated she interviewed residents and family and would document in the grievance book.

On that same date and time, the surveyor asked the [U.S. FOIA (b)] if she had a grievance for [NJ Exec Order 2] from Resident #85 and #42 and she stated, "not that she was aware of." The surveyor asked what constituted [NJ Ex Order 26] and she stated if a resident felt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 610	Continued From page 50	F 610		

they were NJ Exec Order 26.4b1, or any signs of NJ Exec Order 26.4b1 that she would interview the resident and anyone involved. The surveyor asked if there was a process for the investigation and she stated she would look for it.

On 5/28/24 at 11:20 AM (Resident #85) and 01:01 PM (Resident # 42), the U.S. FOIA (b)(6) provided copies of two NJ Ex Order 26.4(b)(1) which he obtained from the NJ Ex Order 26.4(b)(1). The repots both revealed the NJ Exec Order reported the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) at 9:07 AM. The Investigation Report for Resident #42 detailed a narrative and the NJ Exec Order interviewed the resident (U.S. FOIA (b) not indicated as present for this interview as documented in the summary) and the report documented ... the CNA escorted the resident to the bathroom, NJ Exec Order 26.4b1 his/her NJ Exec Order 26.4b1 n Resident #85 ...The narrative for Resident #42 documented ... that after the resident heard the account being NJ Exec Order by Resident #85, he/she informed the staff the he/she was NJ Exec Order 26.4b1 by the same CNA U.S. FOIA (b)(3) not indicated as present for this interview as documented in the summary) ... Resident #42 was escorted to NJ Ex Order 26.4(b)(1) by CNA#3, NJ Exec Order 26.4b1, and NJ Exec Order 26.4b his/her NJ Exec Order 26.4b and then told CNA#3 U.S. FOIA (b)(6) ...

On 5/28/24 11:32 AM, the survey team met with the U.S. FOIA (b)(6). The surveyor asked if there was anything that provided guidance to staff regarding what is supposed to be completed in the event of an NJ Ex Order 26.4(b)(1). At that time, when asked about the investigation related to Resident #85 and #42, the U.S. FOIA (b) confirmed there were no other individual statements taken from any other residents and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 610	Continued From page 51 the [U.S. FOIA (b)(6)] confirmed he did not review the investigation. On 5/28/24 at 11:35 AM the surveyor, asked the [U.S. FOIA (b)] where the supporting documents regarding any interviews of any other residents and any other supporting documentation regarding the investigations. The [U.S. FOIA (b)(6)] stated "I included what I had, everyone that was able to tell me, but only the alert and oriented residents could give me a statement and I did not go to the non-alert residents that could not speak. The At that same time, the [U.S. FOIA (b)(6)] stated we go to the oriented person first, and asked staff if they saw something. The [U.S. FOIA (b)(6)] did not explain why there were no documented interviews or assessments completed with other residents and why non-alert residents were not assessed. The [U.S. FOIA (b)] then stated, she spoke to residents as soon as she found out and it was not documented. On 5/28/24 at 11:50 AM, in the presence of the survey team, the surveyor asked the [U.S. FOIA (b)(6)] about who was responsible to ensure an investigation was completed and he confirmed that he was responsible for the overall process and ensuring the statements were completed. The [U.S. FOIA (b)] stated, "it was just the two CNA's, the one involved and the other one." On 5/28/24 at 12:27 PM, the surveyor interviewed the FM of Resident #42, in the presence of the survey team, regarding the incident. The FM stated the resident told him/her that the [NJ Exec Order 26.4b1] 'NJ Exec Order 26.4b1 The FM also stated that other staff, including a nurse, informed the FM what happened with Resident #42 and CNA#3. The	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 610	Continued From page 52	F 610		

FM also stated that Resident #42 informed his/her U.S. FOIA (b)(6) about what happened. When the surveyor asked the FM if he/she was ever asked to document a statement, the FM responded, "never." The FM also remembered speaking with the CNA who told the FM that Resident #42 NJ Exec Order 26.4b1 Resident #42.

On 5/28/24 at 01:01 PM, the U.S. FOIA (b)(6) provided a second NJ Ex Order 26 policy stated it included the procedures that should have been followed for the investigation. At that time, the surveyor requested the assignments sheets from the U.S. FOIA (b)(6) for CNA#3 for the days he worked when the allegation occurred. The U.S. FOIA (b)(6) stated, that would need to be researched and the U.S. FOIA (b)(6) confirmed the assignment sheets were not part of the investigation.

The policy titled, Abuse Investigation and Reporting Policy, dated 05/01/24 which revealed: Intent: 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 610	Continued From page 53 documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. Role of the Investigator: The individual conducting the investigation will, as a minimum. -Review the completed documentation forms. -Review the resident's medical record to determine events leading up to the incident. - Interview the person(s) reporting the incident. - Interview the resident. -Interview other residents to who the accused employee provides care or services. - Interview the residents' s roommate, family members, and visitors. The following guidelines will be used when conducting interviews: ... -Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. On 5/28/24 at 02:15 PM, the [redacted], upon inquiry by surveyor provided a copy of an [redacted] from the NJ Exec Order 26.4b1 that CNA#3 was sent home early and does not indicate the exact time on [redacted] On 5/29/24 at 12:52 PM, the above concerns were shared with the U.S. FOIA (b)(6) [redacted] and there was no additional information	F 610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 610	Continued From page 54	F 610		

provided during the exit held conference on 05/31/24 at 11:56 AM.
2. On 5/24/24 at 10:29 AM, the surveyor interviewed the U.S. FOIA (b)(6) The U.S. FO stated [he/she] recalled an incident that happened on the NJ Exec Order 26. floor of the facility in the activity room/dining area. The U.S. FO stated the resident was seated in their wheelchair and the U.S. FOIA (b)(6) NJ Exec Order 26.4b1 the resident away from the table. The U.S. FO said it was on camera and the resident filed a complaint. The U.S. FO stated that was the last time [he/she] had seen the U.S. FO.

On 5/28/24 at 11:29 AM, the surveyor observed Resident #35 in their room watching television and socializing with NJ Exec Order 26.4b. Resident #35 was noted to be in their wheelchair and greeted the surveyor at the door and motioned for the surveyor to come in. The resident stated he/she had been at the facility for NJ Exec Order 26.4b1.

On that same date and time, Resident #35 stated the U.S. FOIA was NJ Exec Order 26.4b1 in her approach. Resident #35 stated that the NJ Exec wanted him/her to leave the room and the resident was not ready to. Resident #35 stated, "I was NJ Exec Order 26.4b1 , I told her to stop doing it and she kept doing it." The resident stated he/she reported it to administration and there were other people present but cannot remember who was there.

A review of the resident's most recent quarterly MDS dated NJ Exec Order 26.4 reflected that the resident had a BIMS score of NJ Exec Order 26.4b1 indicating NJ Exec Orde .

A review of the Grievance/Complaint Investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 610	Continued From page 55	F 610		

Report dated [redacted] revealed Resident #35 filed a grievance with the U.S. FOIA (b)(6) [redacted]. The section referencing to documentation of grievance/complaint, documentation of facility follow up and resolution of grievance/complaint read as followed:

-Describe concern briefly using factual terms: (attach resident/family concern form)?
"The resident reported he/she was removed from the NJ Exec Order 26.4b1 [redacted] by the [redacted] when [redacted] asked to NJ Exec Order 26.4b1 when other departments could be present. Resident [redacted] being spoken to in the matter she/he was."

-What other action to resolve concern (be specific)?
"The [redacted] was asked to be mindful of her tone of voice with the residents, as she may come as speaking to loudly and to utilize an approach to gently guide the resident(s) to another aspect or task within the current activity without making them feel interrupted or excluded."

-Was the grievance/complaint resolved?
Yes, "the U.S. FOIA (b)(6) [redacted] informed the resident that the staff member was addressed regarding her approach with the resident. The resident was [redacted] with the resolution."

A review of the attached paperwork to the Grievance/Complaint Investigation Report revealed a statement dated NJ Exec Order 26.4b1 by the [redacted] The statement read as followed.

"Upon the beginning of afternoon rounds, I entered the [redacted]-floor day room and noticed the residents enjoying the activity being held. I

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F 610	Continued From page 56	F 610		

approached the resident where he/she was noted to be participating. The resident explained there was a situation with the [U.S. FO], where resident felt the [U.S. FO] was loud. I explained to the resident that the [U.S. FO] tends to be loud in nature at times which he/she understood. I assured the resident I would further be speaking to the [U.S. FO] to address resident's concerns. I further followed up with the [U.S. FO] regarding the resident's concern from the meeting. I addressed the concern of the resident perceiving her [NJ Ex Order 26.4(b)(1)], the [U.S. FO] agreed she would come to nursing leadership for further interventions when applicable. I returned to the resident and assured the resident I had resolved the matter with the [U.S. FO]. The resident [NJ Ex Order 26.4(b)(1)] with my intervention."

On 5/29/24 at 10:00 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] in the presence of the survey team and the [U.S. FOIA (b)(6)] stated the [redacted] was terminated shortly after, and the facility has no other statements to provide. The [U.S. FOIA (b)(6)] stated the facility does not have video footage of the incident and the surveillance was only kept for 24-48 hours.

On 5/29/24 at 11:04 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] in the presence of the survey team. The surveyor asked the [U.S. FOIA (b)(6)] the steps the facility would take for a resident that complained about an [NJ Ex Order 26.4(b)(1)]. The [U.S. FOIA (b)(6)] stated they would send the person accused of [NJ Ex Order 26] home, call the [NJ Ex Order 26] notify family, [U.S. FOIA (b) (6)] and DOH. The [U.S. FOIA (b)(6)] further stated after notifying everyone, the facility would start to investigate, speak to the resident and any witnesses, and come to a conclusion.

On 5/30/24 at 12:41 PM, the surveyor interviewed the [U.S. FOIA (b)(6)] in the presence of the survey team.

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F 610	Continued From page 57 The [redacted] stated "Yes I learned and need to get statements moving forward." The [redacted] stated we were missing statement, and the facility did not do a thorough investigation. NJAC 8:39-4.1(a)5	F 610		
F 641 SS=C	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the observation, interview, and review of pertinent facility documentation it was determined that the facility failed to accurately code the Minimum Data Set (MDS) for one (1) of the 32 residents reviewed, Resident #89. This deficient practice was evidenced by the following: On 5/21/24 at 9:53 AM, the surveyor observed Resident #89 in the unit day room in a wheelchair feeding themselves during breakfast. The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #89 as follows: According to the Admission Record (admission summary), Resident #89 was admitted to the facility with a diagnosis that included but was not limited to NJ Exec Order 26.4b1 [redacted]	F 641	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Res #89 □ [redacted] assessment was modified by the MDS nurse on [redacted]. There was NJ Ex Order 26.4(b)(1) related to the alleged deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents with falls have the potential to be affected by the deficient practice. All fall assessments were audited for accuracy. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE	7/15/24

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F 641	Continued From page 58 NJ Exec Order 26.4b1 [redacted] A review of the Progress Notes (PN) included the following: 1. Effective date of NJ Exec Order 26.4b1 documented and electronically signed by Licensed Practical Nurse #1 (LPN#1) included that per the incoming nurse, the resident was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) had happened. LPN#1 further documented that there were NJ Ex Order 26.4(b)(1) noted, a NJ Ex Order 26.4(b)(1) assessment was completed, a NJ Exec Order check was activated, physician and family were notified. 2. Effective date of NJ Ex Order 26.4(at 9:00 AM that was electronically signed by LPN#1 about the NJ Exec Order 26.4b1 incident of Resident #89 with NJ Ex 3. Effective date NJ Ex Order 26.4(b) at 12:00 PM that was electronically signed by LPN#1 about s/p (status post) NJ Exec Order 26.4b1 that 11-7 shift nurse reported to LPN#1 that resident complained of U.S. FOIA on the U.S. FOIA (b)(6), the physician was made aware and ordered to NJ Exec Order 26.4b1 for further evaluation. 4. Effective date NJ Ex Order 26.4(at 7:30 PM that was electronically signed by LPN#1 that the resident NJ Exec Order 26.4b1 with a diagnosis of NJ Exec Order 26.4b1 (happens when there's a NJ Exec Orde in one or more of your NJ Exec Order that make up NJ Exec O) and that the responsible party was at the bedside. The resident's Significant Change MDS (SCMDS), an assessment tool used to facilitate the management of care, with an assessment	F 641	DOES NOT RECUR: " The MDS coordinator will audit all fall assessments to ensure accuracy monthly. IV. MONITORING OF CORRECTIVE ACTIONS: " The MDS coordinator/Designee will randomly audit 10 assessments for accuracy monthly, then 5 assessments monthly x 2 months. The results of the audits will be brought to the quarterly Quality Assurance Meeting for review by the Administrator and the Quality Assurance team to assure compliance, and advice on how to proceed	

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F 641	Continued From page 59 reference date (ARD) of [redacted] revealed in Section C Cognitive Status with a BIMS (Brief Interview for Mental Status) score of [redacted] which reflected that the resident's cognitive status was NJ Exec Order 26.4b1. Section J Health Conditions of the SCMDS showed that the resident had [redacted] The SCMDS with an ARD of [redacted] indicated that the resident's BIMS score was [redacted] Section J showed that the resident had NJ Exec Order 26.4b1 Further review of the above MDS showed that the [redacted] with [redacted] on [redacted] was not captured in the SCMDS ARD of [redacted] On 5/23/24 at 10:34 AM, the surveyor interviewed the U.S. FOIA (b)(6) informed the surveyor that the SCMDS ARD [redacted] did not capture the [redacted] with NJ Exec Order 26.4b1 and "it was missed." On 5/24/24 at 10:13 AM, the survey team met with the U.S. FOIA (b)(6) . The surveyor notified the facility management of the above concern with inaccurate MDS that did not capture the NJ Exec Order 26.4b1 SCMDS. The [redacted] stated that it was important that the [redacted] incident was captured in the MDS. On 5/29/24 at 12:02 PM, the survey team met with the U.S. FOIA (b)(6) The facility management did not provide additional information.	F 641		

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F 641	Continued From page 60 NJAC 8:39-11.2(e)(1,2)	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, it was determined that the facility failed to ensure the facility policy was followed and a comprehensive person centered care plan was revised to include target behaviors and	F 657	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	7/15/24

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F 657	Continued From page 61 non-pharmacological interventions for a resident who was administered U.S. FOIA (b)(6) medications. This deficient practice occurred for one (1) of five (5) residents reviewed for NJ Exec Order 26.4b1 (Resident #42) and was evidenced by the following: On 5/28/24 at 8:38 AM, the surveyor interviewed the Certified Nursing Aide (CNA) providing care for Resident #42. The U.S. FOIA (b) stated the resident sometimes NJ Exec Order 26.4b1 The surveyor asked if the resident would become NJ Exec Order 26.4b with the CNA who stated, "resident will try." The CNA also stated the residen NJ Ex Order 26.4(b)(1) but could NJ Ex Order 26.4(b)(1). The surveyor then observed Resident #42 with a NJ Exec Order 26.4b1 on and was walking toward the door in the room, the CNA stated the resident wanted to go see the NJ Exec Order 26.4b On 5/28/24 at 8:43 AM, the surveyor interviewed Resident #42's Licensed Practical Nurse (LPN) at the medication cart and observed Resident #42 walk by and was dressed in a NJ Exec Order 26.4b1. The surveyor asked the LPN about any behaviors the resident had. The LPN stated sometimes complained of NJ Exec O to the NJ Exec Orde The surveyor asked if the resident was on NJ Exec Order 26.4b1 medication (med) and for what indication, and the LPN stated, "yes" for NJ Exec Order 26.4b1 since the NJ Exec Order 26.4b1 which made the resident NJ Exec O The surveyor asked if the resident would leave the unit and the LPN stated the resident went to the other side of the NJ Exec Order 26 floor, and wore an NJ Exec Order 26.4b1 on the U.S. FOIA (b)(6) On 5/30/24 at 11:39 AM, the surveyor conducted	F 657	" The Care Plan of Resident #42 was updated to include target behaviors and non-pharmacological interventions. " Residents were not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents on antipsychotic medications have the potential to be affected by the deficient practice of not having target behaviors and non-pharmacological interventions. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " The Interdisciplinary Team members and Nursing Staff were in-serviced on care plan and revision with focus on developing a comprehensive, person-centered care plan for each resident, to meet each resident medical, nursing, mental, psychosocial needs, target behavior, and non-pharmacological interventions. IV. MONITORING OF CORRECTIVE ACTIONS: " The MDS Coordinator(s) or Designee	

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F 657	Continued From page 62 a telephone interview with the U.S. FOIA (b)(6) [redacted] regarding the monitoring for NJ Exec Order 26.4b1 meds. The surveyor asked if the behaviors for the meds should be documented and should be documented as part of the monitoring, and the [redacted] stated "yes." A review of Resident #42's electronic Medical Record (eMR) revealed: The Admission Record (or face sheet, an admission summary) revealed the resident had diagnoses that included, but were not limited to, NJ Exec Order 26.4b1 [redacted] The current Med Administration Record (MAR) for NJ Ex Order 26.4(b)(1) revealed the following order for NJ Exec Order 26.4b1 [redacted] Give [redacted] times a day for [redacted], Start Date-[redacted]; Monitor for Behaviors every shift-Start Date-[redacted]. There were no identified target behaviors related to the NJ Exec Order 26.4b1 documented in the MAR or quantified. A review of NJ Exec Order 26.4b1 06:53 U.S. FOIA (b)(6) Progress Note revealed: "Diagnosis/Impressions: NJ Exec Order 26.4b1 [redacted] PLAN: 1. Always consider/implement relevant supportive and non-pharmacologic interventions, including: NJ Ex Order 26.4(b)(1) [redacted]. Treat	F 657	will conduct 5 Care Plan Audits weekly x 4 weeks, then 5 Care Plan Audits monthly x 3 months. Audits will focus on verifying the completion of Comprehensive Person-centered Care Plan, to meet the residents medical, nursing, mental and psychosocial needs, target behavior, and non-pharmacological interventions. Results of audits will be reported to the Administrator monthly and presented in the quarterly Quality Assurance Meeting. The Quality Assurance Committee will determine the need for further audits and/or action plans for ongoing.	

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F 657	Continued From page 63 medical issues including NJ Ex Order 26.4(b)(1) [redacted]. Encourage participation in activities, social engagement as tolerated and as possible for psychosocial well being." The current 21-Page Care Plan, including resolved items, and had a Focus for [redacted], Initiated NJ Exec Order 26. and Target Date of NJ Exec Order 26. and a Focus for the use of NJ Exec Order 26.4b1 mediation due to U.S. FOIA (b)(6), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1), Initiated NJ Ex Order 26.4(b)(1) and Target Date NJ Ex Order 26.4(b)(1). An Intervention, "Date Initiated: NJ Ex Order 26.4(b)(1), Monitor/record occurrence of for target behavior symptoms (SPECIFY: NJ Ex Order 26.4(b)(1) [redacted] etc.) and document per facility protocol". The above care plan revealed that it was not revised to reflect specific behavioral expressions. There were no non-pharmacologic interventions as indicated in the NJ Exec Order 26.4b1 documentation. On 5/30/24 at 12:17 PM, the U.S. FOIA (b)(6) [redacted]) stated to the survey team, after the surveyor's inquiry, the team met and reviewed the NJ Exec Order 26.4b1 medications and updated the care plans. The Behavior and Psychoactive Management Program Procedure, dated 05/01/2024 revealed The Facility's behavior Management Program will consist of: 6. Planning and implemented appropriate interventions into the plan of care. 7. Evaluating the effectiveness of Pharmacological and non-pharmacological interventions.	F 657		

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F 657	Continued From page 64 The comprehensive Resident Centered Care Plans Policy, Date: 5/1/24 revealed: Intent: It is the policy of the facility to promote seamless interdisciplinary care for our residents by utilizing the interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation from admission through discharge for each resident. Every resident will have an Interdisciplinary Care Plan. The Care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the residents's strengths, limitations and goals. The care plan will be completed, current, realistic, time specific and appropriate to the needs for each resident ... NJAC 8:39-11.2(e)2	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint NJ #158377 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) document medications and treatments according to physician's orders for one (1) of 32 residents (Resident #18) reviewed for medication and treatment	F 658	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Resident #18 o The physician was notified by the	7/15/24

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F 658	Continued From page 65 administration, and b.) consistently document NJ Ex Order 26.4(b)(1) according to the physician's orders for one (1) of three (3) residents reviewed for NJ Exec Order 26.4b1 (Resident #125) according to standards of clinical practice and facility policy. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.) On 5/21/24 at 9:09 AM, Surveyor #1 observed Resident #18 lying in bed on an NJ Exec Order 26.4b1	F 658	Director of Nursing that on NJ Ex Order 26.4(b)(1) the nurse on duty failed to sign and document in the administration record for resident #18 for multiple physician orders. o The Director of Nursing/designee counseled the nurse who failed to sign the administration record. o All nurses were in-service regarding the importance of signing the administration record after providing care. o Resident #18 was not adversely affected by the deficient practice. " Resident #125 o The physician was notified by the Director of Nursing that the nurses on duty failed to sign and document in the administration record for NJ Exec Order 26.4b1 for resident #18 on multiple days. o The Director of Nursing/designee counseled the nurses who failed to sign the administration record for NJ Ex Order 26.4(b)(1). o All nurses were in-service regarding the importance of signing the administration record after providing care. o Resident #125 was NJ Ex Order 26.4(b)(1) [redacted] by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents with urinary catheters	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 658	Continued From page 66 wearing [NJ Exec Order 26.4b] and the call bell in reach. Resident #18 was [NJ Exec Order 26.4b1] and stated he/she was in the hospital recently and had been at the facility [NJ Exec Order 26]. Resident #18 was unable to tell the surveyor of all the previous hospitalizations. Surveyor #1 reviewed a previous readmission record for Resident #18. Resident #18's Admission Record (AR, or face sheet, an admission summary) reflected a readmission from the hospital with diagnoses included but were not limited to; [NJ Exec Order 26.4b1] [redacted] A review of the facility provided, "Physician Orders" report from the previous electronic medical record system, included the following: Created [NJ Ex Order 26.4(b)(1)], 26 orders including medications (meds), treatments, supplements, and tasks. A review of the electronic Medication Administration Record (eMAR) and the electronicTreatment Administration Record (eTAR) both dated [NJ Ex Order 26.4(b)(1)], revealed the following documentation of "X" "Not Addressed" on [NJ Ex Order 26.4(b)(1)]: [NJ Exec Order 26.4b1] [redacted] :00 [NJ Ex] :00 [NJ Exec Order 26.4b1] [redacted] :00 [NJ Ex] :00	F 658	have the potential to be affected by deficient practice. All residents with urinary catheters were reviewed to ensure the treatment administration record was completed for urinary output. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " All nurses were in-serviced on the need to maintain professional standards of clinical practice when following physician□s orders and on following facility policies for medication administration. " All nurses were in-serviced on the need to maintain professional standards of clinical practice when signing the medication administration record for medications and treatment orders . o Emphasis was made on the following: ¿ Signing medication and treatment orders. ¿ Documenting urinary output on resident with urinary catheters. IV. MONITORING OF CORRECTIVE ACTIONS: " Director of Nursing or designee will review the Medication Administration Records (MARS) and Treatment Administration Records	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 658	Continued From page 67 NJ Exec) NJ Exec Order 26.4b1 :00 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 :00 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1) NJ Exec Order 26.4b1 :00 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1	F 658	(TARs) of 5 residents monthly for 3 months to check whether the assigned nurse(s) are signing orders after administering medications and treatments as per physician orders. " Director of Nursing will review the Treatment Administration Record (TAR) for 2 residents with urinary catheter(s) monthly for 3 months to check if nurses are documenting urine output as per physician orders. " Findings will be reported to the Director of Nursing and administrator monthly and will be presented at the quarterly Quality Asuurance Meeting. The Quality Assuarnce Committee will determine the need for further audits and/or action plan.	

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F 658	Continued From page 68 A review of the resident-centered on-going care plan (CP) included but was not limited to; dated NJ Ex Order 26.4(b): at NJ Exec Order 26.4b1 with interventions including assist with NJ Ex Order 26.4(b)(1) and administer medications as ordered. At risk for NJ Exec Order 26.4b1 with interventions assist with NJ Ex Order 26.4(b)(1), administer NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4 treatments as ordered. At risk for NJ Exec Order 26.4b1 history of recurrent NJ Exec O use of NJ Exec Order 26.4b1 with interventions NJ Exec Order 26 NJ Exec Order 26.4b per orders, observe for signs and symptoms of infection, change NJ Exec Order 26.4b as ordered, NJ Exec Order 26.4b care as ordered, and NJ Exec Order NJ Exec Order 26.4b1 NJ Exec O every shift. A review of the Progress Notes (PN) ranging from NJ Exec Order 26.4b1, contained no documentation as to why the meds, treatments, and tasks were marked as not addressed. The PN contained no documentation to the physician or family regarding the meds, treatments, and tasks marked as not addressed. On 5/29/24 at 9:41 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) was questioned if a eMAR or eTAR documented an "x", what would that indicate. The U.S. FOIA (b) stated it would mean "not given" and that "there are codes on the bottom [of the eMAR/eTAR] to indicate the documentation." She further explained that if a resident did not receive a med or treatment, the expectation would be to see a PN, call the pharmacy, and call the physician. The U.S. FOIA (b) stated, "There should always be a code why med was not given and a PN."	F 658		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 69 On 5/29/24 at 12:03 PM, the survey team met with the facility administration. Surveyor #1 presented the concerns regarding Resident #18. On 5/30/24 at 10:25 AM, the facility [U.S. FOIA] [redacted]) stated the facility reached out to the nurses working [NJ Exec Order 26], but it was too long ago, and the nurses could not provide any information. She further stated that if the documentation was noted as "not addressed," the staff should have reached out to the physician, but "we have nothing else." At that time, the [U.S. FOIA (b)] acknowledged that the facility was responsible to provide the ordered meds and treatments, but there was no more information the facility could provide. The [U.S. FOIA (b)] further stated that if a resident was not provided physician ordered meds or treatments, that the resident condition could worsen. 2.) Surveyor#2 (S#2) reviewed the medical record for Resident #125. Resident #125's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to [NJ Exec Order 26.4b1] [redacted] The most recent comprehensive Minimum Data	F 658		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 658	Continued From page 70 Set (cMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had an [redacted]. The cMDS also showed that the resident had an [redacted] A review of the Order Summary Report (OSR) for [redacted] reflected a physician's order (PO) dated [redacted] Care every shift. The order was plotted in the [redacted] eTAR for day, evening, and night shifts to include the [redacted] The [redacted] eTAR revealed the [redacted] was not documented for the following days and shifts: [redacted] evening and night shifts [redacted] evening shift [redacted] to [redacted] evening shift [redacted] evening shift [redacted] evening shift [redacted] evening shift On 5/24/24 at 10:13 AM, the survey team met with the [redacted] S#2 notified the facility management of the above findings and concerns regarding omitted documentation of [redacted] in the [redacted] eTAR and did not follow the PO. On that same date and time, both the [redacted] stated that they (nurses) should put an [redacted] or zero if no [redacted] in the eTAR and follow the PO.	F 658		

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F 658	Continued From page 71 On 5/28/24 at 8:33 AM, the surveyor observed Resident #125 in their room seated in a wheelchair during breakfast. According to the resident, the NJ Exec Order 26.4b1 was due to U.S. FOIA (b)(6) [redacted] On 5/29/24 at 12:02 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] The surveyor discussed the above concerns. A review of the facility's NJ Ex Order 26.4(b)(1) [redacted] dated NJ Ex Order 26.4(b) that was provided by the US FOIA (b) (6) [redacted], included that it is the policy of the facility to ensure the appropriate use of NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1) in accordance with state and federal regulations, and national guidelines. Procedure: #9. Documentation to include NJ Ex Order 26.4(b)(1) and monitoring for signs and symptoms of infection. On 5/30/24 at 11:59 AM, the survey team met with the U.S. FOIA (b)(6) [redacted] The U.S. FOIA (b) [redacted] stated that the nurse failed to put the NJ Exec Orde [redacted] in the eTAR according to the PO. She further stated that the nurse should follow the order to document the NJ Exec Order [redacted] in the eTAR.	F 658		
F 684 SS=F	NJAC 8:39-27.1(a), 33.2 (c) 5 Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		7/15/24

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F 684	Continued From page 72 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ162913 Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure there was no delay in addressing laboratory (lab) values in a timely manner for two (2) of two (2) residents (Resident #6 and #109), b.) notify the physician of the the change in condition generated by a [health alert system] for three (3) of three (3) residents (Residents #6, #109, and #330), c.) NJ Exec Order 26.4b1, specifically the NJ Exec O of Resident #109, who had a known behavior of NJ Ex Order 26.4(b)(1) and d.) provide NJ Exec Order 26 care in accordance with professional standards of practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 684	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " The NJ Ex Order 26.4(b)(1) values for residents #109 and # 6 were reported to the primary MD on NJ Exec Order 26.4b1 no new orders were given, and NJ Exec Order 26.4b1 [redacted] related to the deficient practice. " Treatment was in place for resident #109 from NJ Ex Order 26.4(b)(1) with no further concerns as to the presentation of the NJ Exec Order 26.4b. The primary MD was made aware with no further orders. " Resident # 330 is NJ Exec Order 26.4b1 [redacted]. " All nurses were re-educated to notify the physician and document the notification upon receiving any notification from the health alert system. " Resident # 330 is NJ Exec Order 26.4b1 [redacted] II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the same deficient practice.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 684	Continued From page 73 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 5/21/24 at 10:04 AM, the surveyor observed Resident #109 seated in the room. The surveyor observed some NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. The resident was unable to participate in an interview. On 5/22/24 at 10:43 AM, the surveyor observed the resident sitting in the room. The electronic Medical Record (eMR) was then reviewed which revealed that the resident had sustained NJ Exec Order 26.4b1 at the facility and that Resident #109 was a NJ Exec Order 26.4b1. On 5/23/24 at 8:40 AM, the surveyor observed the resident in bed, and at 9:44 AM, the surveyor observed the resident sitting in a wheelchair in the room and was eating breakfast. The surveyor again reviewed Resident #109's eMR which revealed: The Admission Record (AR, or face sheet, an admission summary) reflected that Resident #109 was admitted to the facility with diagnoses which	F 684	" All current residents with laboratory draws were audited on 5/29/24 for unreviewed results with no deficient practice found. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " The nursing supervisor/designee will print all laboratory reports for labs done daily and ensure that they are addressed daily. " The Director of Nursing/Designee will review all health alerts daily to ensure MD notification and follow up is completed. " All nurses were educated on reporting change in condition including changes in skin condition to the Primary physician. IV. MONITORING OF CORRECTIVE ACTIONS: " The Director of Nursing/Designee will audit 5 residents with lab draw, health alerts, and change in skin condition weekly x 4 weeks, then 5 residents bi-weekly for 2 months for compliance. Findings will be reported to the Director of Nursing and administrator monthly and will be presented at the quarterly Quality Assurance Meeting. The Quaility Assurnace Committee will determine the need for	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 684	Continued From page 74 included, but was not limited to; other NJ Exec Order 26.4b1 [redacted] The Annual and the Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, respectively dated NJ Exec Order 26.4b1 indicated that Resident #109 scored NJ Exec Order [redacted] on the Brief Interview for Mental Status (BIMS) indicating NJ Exec Order 26.4b1 . Review of a Nursing Progress Note (PN) dated NJ Ex Order 26.4(b) at 01:22 PM, indicated that Resident #109 had a NJ Exec Order 26.4b1 [redacted], reported from "NJ Exec Order 26.4b1 ." NJ Exec Order 26.4b1 and NJ Ex Order 26.4(b)(1) applied for NJ Ex Order 26.4(b)(1) On NJ Ex Order 26.4(at 23:07 the nurse documented: [redacted] issue # 001 Needs Review. Issue type: NJ Exec Order 26.4b1 Location NJ Exec Order 26.4b1 #002 Needs review Issue type NJ Exec Order 26.4b1 U.S. FOIA (b) [redacted]. #003 Needs Review Issue Type: NJ Exec Order 26.4b1 Location: U.S. FOIA (b)(6) . NJ Ex Order 26.4(b)(1): NJ Ex Order 26.4(b noted to NJ Exec Order 26.4b1 ., and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Another entry dated NJ Ex Order 26.4(time 11:39 PM indicated the following: [redacted] noted to NJ Exec Order 26.4b1 arm, endorse to night nurse to follow up with NJ Exec Order [redacted] care nurse.	F 684	further audits and/or action plan.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 684	Continued From page 75	F 684		

Further review of the medical record revealed there was no documentation regarding the [redacted] to indicate any follow up was completed. A review of the Physician PN did not reflect evidence that the attending Physician was aware of the resident's [redacted] having a [redacted]. There was no documented evidence that the [redacted] was addressed with the Physician. The facility did not alert the Physician of the change in condition regarding the [redacted] on [redacted] to the [redacted]. The [redacted] was not [redacted]

The PN of [redacted] timed 3:13 PM revealed: [health alert system] (remote patient monitoring device placed within a detectable range of each patient that alerted the staff of any change in condition). "Protocol" Upon receiving the alert, the resident had to be assessed, vital signs had to be monitored every shift for 3 days, [redacted], Comprehensive [redacted] profile and and [redacted]) had to be ordered. Staff were to monitor the [redacted] and alerted the [redacted] of the result. Resident #109 had another [health alert system] alert on [redacted] 50 [9:50 PM]. [redacted] at 5:53 AM revealed a [redacted]. Normal Range [redacted]. The result was forwarded at 3:56 PM.

The surveyor reviewed the result on the eMR with the [redacted] Both the surveyor and the [redacted] noted that the result was marked as "Not reviewed" on [redacted]. There was no documented evidence that the Physician was notified of the [redacted]

On 5/29/24 at 10:36 AM, during an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 684	Continued From page 76	F 684		

the Physician, he revealed that he was not informed of the NJ Exec Order 26.4b1 or any change in condition regarding Resident #109. He acknowledged that he reviewed the NJ Ex Order 26.4(b)(1) today NJ Ex Order 26.4(NJ Ex Order 26.4(later).

2. The surveyor reviewed the medical records of Resident #6 as follows:

Resident #6 was admitted to the facility with diagnoses which included, but were not limited to NJ Exec Order 26.4b1

The Quarterly MDS dated NJ Exec Order 26.4b1 revealed that Resident #6 had a BIMS score NJ Exec Order 26.4b1 indicative of NJ Exec Order 26.4b1

On 5/02/24 Resident #6 had a [health alert system] alert. The protocol was for a physical assessment to be done, vital signs and NJ Ex Order 26.4(b)(to be completed and report any NJ Ex Order 26.4(b)(1) to the Physician. Resident #6's NJ Exec Order 26.4b1 was collected on NJ Exec Order 26.4b1 The result was available the same day at NJ Exec Order 26.4b1 A NJ Exec Order 26.4b1

The facility did not checked the result or alert the Physician of the [health alert system] alert. The result status was checked and revealed that the NJ Exec Order 26.4b1 had not been reviewed as of NJ Exec Order 26.4 (NJ Ex Order 26.4(b later).

On 5/29/24 at 9:15 AM, the surveyor interviewed the U.S. FOIA b regarding the [health alert system] alert and the NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(with the

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 684	Continued From page 77	F 684		

NJ Exec Order 26.4b1 for Resident #6. The U.S. FOIA b informed the surveyor that she was not made aware that Resident #6 had NJ Exec Order 26.4b1 on NJ Ex Order 26.4(b) Regarding the NJ Exec Order 26.4b1 she informed the surveyor that she would have addressed it if she was was made aware.

On 5/29/24 at 10:36 AM, the surveyor interviewed the Physician in charge of Resident #6's care. The Physician stated that the [health alert system] alert was a good system that can alert of any change in condition and avoid hospitalization. However, the staff needs to communicate with the physician. The Physician stated that he was not made aware of the [health alert system] alert and the abnormal lab result. The physician stated that his expectations were the facility will either communicate with the physician or the U.S. FOIA b any concerns regarding the resident.

3. On 5/23/24 the surveyor reviewed the closed medical record of Resident #330.

Resident # 330 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1

The New Jersey Universal Transfer Form dated NJ Ex Order 26.4(b)(1) reflected that Resident # 330 was admitted with NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 measuring NJ Exec Order 26.4b1 The admission record NJ Exec Order 26.4b1 contained an order to provide NJ Ex Order 26.4(b)(1) every shift. Cover with layer of NJ Exec Order 26.4b1 NJ Ex Order 26.4(b)(1). Call NJ Exec Order 26 care nurse for any changes in NJ Exec Order 26 characteristics. NJ Ex Order 26.4(b)(1): NJ Exec Order 26.4b1 NJ Ex Order 26.4(type: NJ Exec Order 26.4b1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 684	Continued From page 78 Stage: NJ Exec Order 26.4b1 Cleanse with NJ Exec Order 26.4b1, apply NJ Exec Order 26.4b1 : Every shift. The physician order sheet dated NJ Exec Order 26.4b1 had an order for Resident #330 to be NJ Ex Order 26.4(b)(1) every or within two hours of last NJ Ex Order 26.4 The surveyor reviewed the PN and noted that staff documented that the resident was being NJ Exec Order 26.4b1 as ordered and that NJ Exec Order 26 care was being done. The NJ Exec Order 26.4b1 assessment dated NJ Exec Order 26.4b1 timed 01:29 AM, revealed that the resident was a NJ Exec O and was constantly NJ Exec Orde by NJ Exec Order 26.4b1. Resident # 330 received a score of NJ Exec indicative of NJ Exec Order 26.4b for NJ Exec Order 26.4b1 On 3/02/23 the Health Status Note dated NJ Exec Order 26.4 indicated that Resident #330 was seen by the NJ Exec Order 26.4 nurse and the NJ Exec Order 26 treatment was changed from NJ Exec Order 26.4b1 and replaced with NJ Exec Order 26 a NJ Exec Order 26.4b1 agent. The electronic Treatment Administration Record (eTAR) was not signed to indicate that the NJ Exec Order 26 care was being done from NJ Exec Order 26.4b1 A NJ Exec Order 26.4b1 was ordered for every evening shift on NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4. The NJ Exec Order 26.4b1 was not signed as being done on NJ Exec Order 26.4. The eTAR revealed an order for NJ Exec Order 26 to apply to NJ Exec Order 26.4b1 every shift for NJ Exec Order 26.4b1 with a start date of NJ Exec Order 26.4. The eTAR was not initialed on NJ Exec Order 26.4b The eTAR was left blank. There was no rationale to indicate why the NJ Exec Order 2 care was not documented as completed on those NJ Exec days.	F 684		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 684	Continued From page 79 On NJ Exec Order 26.4 timed 23:54 (11:54 PM), a NJ Exec Order 26.4b1 issue was identified. The Physician entered a late entry dated NJ Exec Order 26.4b1 "Resident was seen for NJ Exec Order 26 Consultation follow up for NJ Exec Order 26 management of NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 region and NJ Exec Order 26.4b1 l region:  Plan discussed with primary Physician. If applicable, NJ Exec Order 26.4b1, Application of NJ Ex Order 26.4(b)(1) A PN dated NJ Ex Order 26.4(b) timed 20:24 [8:24 PM], documented that the Resident Representative (RR) was upset over the NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1 not being provided in a timely manner. According to the documentation the NJ Exec Order 26.4b1 was not done as ordered. (The eTAR indicated that NJ Exec Order 26 NJ Exec O was not completed on NJ Exec Order 26.4b1 On NJ Exec Order 26.4 timed 20:24 the Licensed Practical Nurse (LPN) documented the responsible party (RP) came in very upset c/o [complain of] resident NJ Exec Order 26.4 getting NJ Exec Order within a NJ Exec Order 26.4b1	F 684		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 684	Continued From page 80	F 684		

period, saying Resident #330 not being [NJ Ex Order 26.4(b)(1)] in a timely manner. Resident [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b] at 18:00 (6:00 PM). "The morning nurse said she got busy and could not do [NJ Ex Order 26.4(b)(1)]."

An entry dated [NJ Ex Order 26.4(b)] timed 20:38 PM (8:38 PM), revealed that the [U.S. FOIA (b)(6)] from the agency arrived to the floor at [NJ Exec Order 26.4] and indicated that the RP was upset regarding the care. The nurse went to the [NJ Exec Order 26.4b] and observed two Certified Nursing Assistant (CNA) performing [NJ Exec Order 2] care to Resident #330's [NJ Exec Order] The [U.S. FOIA (b)(6)] was not on the floor at that time. The RP went to the [NJ Ex Order 26.4(b)(1)] and filed a complaint regarding the care. The RP took the resident [NJ Exec Orde] the same day at [NJ Exec Order 26.4b1].

The facility administration was interviewed and did not provide any documentation regarding the above documented concerns.

A review of the Certified Nursing Assistant Job Description under specified duties revealed the following" Assists the resident in maintaining and improving function, encouraging independence whenever responsible for the Activities of Daily Living, and overall hygiene of the resident: baths, shampoos, shaves, nail care mouth care, foot care and peri-care per facility policy.

The job description did not indicate that CNA would perform wound care.

A review of the Registered Nurse (RN) Job description indicated the following:

As member of the Interdisciplinary team, the RN assumes responsibility and accountability for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 684	Continued From page 81 nursing services delivered to assigned residents of a designated unit for one shift. The RN provides direct care, administers treatments and medication, organize and distribute daily assignments to direct care staff consistent with staff competency and each individual resident's comprehensive resident assessment and plan of care. Supervises direct care staff and makes decisions about resident care needs during shifts concerning scope of clinical competence, consistent with facility policies and procedures. Ensures that "Flow of Care " is followed. The Director of Nursing (DON) job description indicated that the DON assumes full time administrative and clinical authority for the delivery of nursing services in the facility. Manages employees in the provision of care and services according to professional standards of nursing practice, consistent with facility philosophy of care and state and federal laws and regulations. Develops and implements policies and procedures consistent with current law. In collaboration with the Nursing Home Administrator, allocates department resources in an efficient and economic manner to enable each resident to attain or maintain the highest practicable physical, mental and psychosocial well-being..... Makes daily rounds on unit to supervise, observe, examine, interview residents, to evaluate staffing needs, to monitor regulatory compliance, to achieve the care environment and to evaluate staff interactions and clinical skills competency. Review 24 hours reports from every unit daily to ensure timely, effective responses to significant changes in condition, transfers, discharges, use of physical or chemical restraints, unexplained injuries, potential abuse or neglect, medication errors, loss of resident	F 684		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 684	Continued From page 82 property, any evidence of resident or family dissatisfaction. The [U.S. FOIA (b)] could not comment on the documentation regarding Resident #330 as she was not employed at the facility when the incident occurred. On 5/30/31 at 01:15 PM, the survey team met with the U.S. FOIA (b)(6) [redacted]. The administrative staff did not provide any rationale for not informing the Physician of the change in condition for both residents. The [U.S. FOIA (b)] acknowledged that the nurse should have notified the Physician regarding the laboratory work result.	F 684		
F 689 SS=H	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to: a) ensure adequate [NJ Exec Order 26.4b1] was provided to a resident to prevent [NJ Exec Ord] b) follow the facility	F 689	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 83 accident policy to investigate [NJ Exec Orde] and c) initiate and implement appropriate care plan interventions to prevent [NJ Exec Order 26.4b1] This deficient practice occurred for two (2) of two (2) residents reviewed (Resident # 89 and #109) for [NJ Exec O] with [NJ Exec Order 26.4b1] who were identified as being at [NJ Exec O] [NJ Exec Orde], sustained multiple [NJ Exec Orde] including [NJ Exec Orde] that required transfer to the [NJ Exec Order 26.4b1] for evaluation and treatment. The deficient practice was evidenced by the following: A review of the facility's "Reporting Accidents and Incidents Policy" dated 05/01/24, provided by the Vice President of Risk Management (VPoRM), indicated: #5 The Nursing Supervisor or designee will add the investigation results to the Event and conclude it. #6 The Nursing Supervisor and designee will add the investigation results into the Event and conclude it. The DON or designee will track incidents and accidents on the facility surveillance log to determine patterns and trends. #7 Monthly/Quarterly during the Facility Quality Assurance and Performance Improvement Meeting the results of the Incident and Accident Tracking System will be evaluated. #8 The facility will provide an environment that is free from accidents hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents.. This includes: a. Identifying hazard (s) and risks (s). b. Evaluating and analyzing hazard (s) and risk(s). c. Implementing interventions to reduce hazard(s) and risk (s).	F 689	" Al [NJ Exec] incidents and care plans for residents #89 and #109 were immediately reviewed on [NJ Exec Order 26.4b] A list was compiled for the surveyor highlighting the root cause analysis and the interventions for every [NJ Exec] II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents with falls have the potential to be affected by the same deficient practice. " All care plans of residents with falls were reviewed by the nursing team to the appropriate interventions were in place on 5/30/24. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " The Interdisciplinary Team was educated on proper fall root cause analysis process focusing on documenting Interdisciplinary Care Plan (IDCP) notes, Identify the root cause analysis, updating care plan, and timing and implementation of new interventions. " The Director of Nursing/Designee will bring all fall reports to the IDCP meeting for review of root cause analysis and propre	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 84 d. Monitoring effectiveness and modifying interventions when necessary. #10 The facility will ensure each resident receives adequate supervision and assistive devices to prevent accidents. #15 The facility will conduct an internal risk management and quality assurance program which includes the use of incident reports to be filed with the Director of Nursing (DON) and facility administrator. The DON shall have free access to all resident records of the licensed facility. A review of the Comprehensive Resident Centered Care Plans Policy with a date of 5/01/24 that was provided by the [redacted] included that it is the facility's purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable, and based on resident needs. A resident's care should have the appropriate intervention and provide means of interdisciplinary communication to ensure continuity in resident care. Each planned intervention will be specific and include parameters for frequency and time schedule. 1. On 5/21/24 at 10:04 AM, the surveyor toured the [redacted]-floor unit and observed Resident #109 seated in a wheelchair (w/c) at the bedside with [redacted] to the [redacted], and a [redacted] to the [redacted]. The surveyor was unable to interview the resident due to [redacted] On 5/21/24 at 11:45 AM, 5/22/24 at 10:43 AM, and 5/23/24 at 9:44 AM, the surveyor observed Resident #109 sitting in a w/c in their room unsupervised.	F 689	intervention. " The Director of Nursing /Designee will review all fall incidents monthly to ensure compliance. IV. MONITORING OF CORRECTIVE ACTIONS: " The Director of Nursing/Designee will audit 4 fall incidents weekly for 4 weeks to ensure compliance, then 4 fall incidents biweekly for 2 months. Findings will be reported to the Director of Nursing and administrator monthly and will be presented at the quarterly Quality Assurance Meeting. The Quality Assurance Committee will determine the need for further audits and/or action plan.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 85 On 5/23/24 at 8:40 AM, the surveyor observed Resident #109 in bed unsupervised. The surveyor reviewed the medical records of Resident #109 and revealed: The Admission Record (AR) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] The Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care with an assessment reference date (ARD) of [redacted] and the Significant Change MDS (SCMDS) dated [redacted] reflected a brief interview for mental status (BIMS) score of [redacted] which reflected that the resident's cognitive status was [redacted]. The MDS also included Section GG Functional Status in which the resident required [redacted] with [redacted] and transfer, used a w/c for locomotion, and had [redacted]. A review of Resident #109's comprehensive Care Plan (CP) provided by the facility on [redacted], revealed: A focus area: "Resident #109 is [redacted] for [redacted] related to history of [redacted] diagnosis of [redacted] drug use" initiated [redacted]. The goal was that Resident #109 would be free of [redacted] through the review date of [redacted] The [redacted] CP interventions included but were not limited to:	F 689		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 689	Continued From page 86	F 689		

Initiated [NJ Ex Order 26.4(b)]: Anticipate and meet needs; Assure the resident is wearing appropriate [NJ Exec Order 26.4b]; Be sure the call light is within reach and encourage the resident to use it for assistance as needed; Educate the resident/family/caregivers about safety reminders and what to do if a [NJ Exec] occurs; Follow facility [NJ Exec] protocol; Review information on past [NJ Exec] and attempt to determine the cause of [NJ Exec] Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregiver/IDT (interdisciplinary team) as to causes.
Initiated on [NJ Ex Order 26.4(b)]: Continue [NJ Exec Order 26.4b1] to address deficits.
Initiated [NJ Ex Order 26.4(b)(1)]: [NJ Exec Order 26.4b1]) to the w/c.
Initiated [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4] evaluation as a possible treatment.
Initiated [NJ Ex Order 26.4(b)(1)] Continue with [NJ Ex] to address deficits.
Initiated on [NJ Ex Order 26.4(b)] and revised on [NJ Ex Order 26.4(b)]: Medication Evaluation.
Initiated on [NJ Ex Order 26.4(b)]: Monitor hourly; Offer [NJ Ex Order] hourly while awake.

The ADL (activities of daily living) CP interventions included but were not limited to: [NJ Ex Order] the resident required [NJ Ex Order 26.4(b)(1)] from staff. Initiated and revised on [NJ Ex Order 26.4(b)(1)].

On [NJ Exec Order 26.4b1], the surveyor requested all investigations, [NJ Exec] Risk Assessments and a timeline for review from the [NJ Exec Order]

The following Incident/Accident (I/A) Reports with additional documentation revealed the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 87 1. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 floor dining area. The resident was NJ Exec Order 26.4b1 the incident. The resident complained of NJ Exec Order 26.4b1, was transferred to the hospital for further evaluation, and diagnosed with NJ Exec Order 26.4b1 -There were no Interdisciplinary Care Plan (IDCP) Notes regarding the NJ Exec O. 2. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 in the resident's room. The resident NJ Exec Order 26.4b1, that resulted in a NJ Exec Order 26.4b to the NJ Exec Order 26.4b1. The resident was sent to the hospital and required NJ Exec Order 26.4b1. -IDCP Notes did not identify the root cause analysis. NJ Exec O CP was not updated to reflect any new intervention. 3. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 in resident's room. The resident NJ Exec O trying to go to the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the NJ Exec -IDCP Notes did not identify the root cause analysis. -NJ Exec O CP was not updated to reflect any new intervention. 4. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1. The resident attempted to NJ Ex Order 26.4(b)(1) in the w/c. -IDCP Notes and NJ Exec O CP showed NJ Exec Order 26.4b1 to w/c as part of the new intervention. 5. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 in	F 689		

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F 689	Continued From page 88 resident's room. The staff heard Resident #109 NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 when NJ Exec Order 26.4b1 NJ Ex Order 26.4 confirmed the resident had a NJ Exec Order 26.4b1 and was medicated with NJ Exec Order 26.4b1 . The resident was transferred to the hospital for treatment and returned on NJ Exec Order 26.4b1 . -IDCP Notes and NJ Exec CP initiated U.S. FOIA (b)(6) evaluation and treatment. 6. NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 in resident's room with no injury. The staff observed the NJ Exec Order 26.4b1 . The resident was NJ Exec Order 26.4b1 what happened. -IDCP Notes did not identify the root cause analysis. NJ Exec Ord CP was not updated to reflect any new intervention 7. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 . The staff found the resident NJ Exec Order 26.4b1 . NJ Exec Order 26 evaluation from an earlier incident continuted and staff to closely monitor the resident was added. NJ Exec O CP was not updated to reflect any new intervention. -There was no documentation provided regarding the how staff was to monitor the resident. 8. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in resident's room. The resident was found by U.S. FO Staff on the NJ Exec Order 26.4b1	F 689		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 89 NJ Exec Order 26.4b1. The resident NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. Licensed Practical Nurse #1 (LPN#1) documented immediate interventions to have a call bell within reach and continue to frequently monitor. -IDCP Notes did not identify the root cause analysis. -NJ Exec CP was not updated to reflect any new interventions. -There was no documentation provided regarding the how staff was to monitor the resident. 9. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Certified Nursing Aide #1 (CNA#1) heard a noise and found the NJ Exec Order 26.4b1 [redacted]. Interventions included to remind the resident to use the call light and continue with NJ Exec Order 26 [redacted]. -IDCP Notes did not address the root cause analysis. -There was no documentation provided regarding the how staff was to monitor the resident. 10. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in resident's room. The resident stated he/she was going to NJ Exec Order 26.4b1. The nurse found the resident on the NJ Exec Order 26.4b1. The NJ Exec D Inspection Report identified the resident as supervision on transfer status. Per the ADL CP, Resident #109 required NJ Exec Order 26.4b1 [redacted] from staff. -IDCP Notes did not identify the root cause analysis NJ Exec C CP was not updated to reflect any new intervention. -ADL CP was not followed.	F 689		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 90 -There was no documentation provided regarding the how staff was to monitor the resident. 11. NJ Exec Order 26.4b1, [redacted] in [redacted]. NJ Exec Order 26.4b1 [redacted] The resident was unable to describe what happened due to NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 Report identified the resident as set up, NJ Exec Order 26.4b1 t on [redacted] status. Per the ADL CP, Resident #109 required NJ Exec Order 26.4b1 [redacted] for [redacted] from staff. The facility continued the intervention of monitoring frequently. [redacted] CP was not updated to reflect any new intervention. -ADL CP was not followed. -There was no documentation provided regarding the how staff was to monitor the resident. 12. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in the [redacted]-floor hallway. The resident stated they were NJ Exec Order 26.4b1. The resident NJ Exec Order 26.4b1 [redacted] -IDCP Notes and [redacted] CP intervention was to keep the resident in a supervised area as much as the resident would allow but was not initiated unti[redacted]. 13. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in the dining room with [redacted]. CNA#2 witnessed Resident #109 got up from the chair, NJ Exec Order 26.4b1 [redacted] The resident was NJ Exec Order 26.4b1 as part of the facility's intervention. [redacted] CP was not updated to reflect any new	F 689		

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F 689	Continued From page 91 intervention. 14. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in resident's room. The staff heard a NJ Exec Order in the room and saw the NJ Exec Order 26.4b1 Interventions included hourly NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b schedules. -There was no documentation provided regarding the hourly NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b schedules. 15. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 in resident's room. The resident got up to use the NJ Exec Order 26.4b1. The resident NJ Exec Order 26.4b1 and was sent to the ER. -The I/A Report was incomplete. -There was no documentation provided regarding the hourly NJ Ex Order 26.4(b)(1 and NJ Ex Order 26.4(b schedules. Further review of the above I/A Reports showed that on six occasions (NJ Ex Order 26.4(b)(1 at 8:40 PM; NJ Ex O at 10:30 PM; NJ Ex Order at 01:10 PM; NJ Ex Order at 5:30 PM; NJ Ex Order and NJ Ex Orde) Resident #109 NJ Exec while attempting to NJ Ex Order 26.4(b)(1). There was no evidence that the facility identified this as a root cause analysis. On 5/28/24 at 9:30 AM, the surveyor interviewed the NJ Exec Orde regarding the multiple NJ Exec O documented for Resident #109 and the interventions implemented. The NJ Exec Order 2 along with the U.S. FOIA , provided an Investigation Summary and Conclusion regarding the NJ Exec Order 26.4b1. The U.S. FOIA (b)(6) stated that the Investigation Summary and Conclusion was done after the surveyor's inquiry. He further stated that the facility acknowledged	F 689		

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F 689	Continued From page 92	F 689		

the surveyor's concern. The facility indicated that Resident #109's NJ Exec Order 26.4b1 and NJ Exec Order 26 [redacted] had been a challenge to preven[redacted]

At that same time, the facility management could not provide documentation that the root cause analysis was identified after each[redacted], CP interventions were updated or revised and describe how staff were to monitor the resident.

On 5/28/24 at 10:30 AM the surveyor had a telephone interview with Resident #109's Representative (RR). The RR informed the surveyor that Resident #109 NJ Exec Order 26.4b1 [redacted]. The RR further stated that the resident was admitted to the hospital after the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 [redacted]. The RR also stated that Resident #109 was [redacted].

On 5/28/24 at 11:08 AM, the surveyor interviewed the Registered Nurse (RN) regarding the [redacted] protocol. The RN stated that Resident #109 was identified as a NJ Exec Order 26.4b1. The interventions implemented were: close [redacted] removal of [redacted] in the room to promote safety, and frequent [redacted]. The RN further stated that all residents identified to be at NJ Exec Order 26.4b1 were to be closely monitored. The RN also stated that the CP should be revised after each [redacted]

On that same date and time, the RN stated that Resident #109 had been in [redacted] due to NJ Exec Order 26.4b1. The surveyor reviewed the CP with the RN and the RN verified that the CP was not updated after [redacted] and the root cause was

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F 689	Continued From page 93 not identified. The RN stated Resident #109 was not monitored by staff. On 5/29/24 at 1:00 PM, the [redacted] provided a copy of the NJ Exec Order 26.4b1 [redacted] Risk Assessment) with the following information: Effective date: [redacted] Category: NJ Exec Order 26.4b1 Score: [redacted] Instructions: Completed on admission, quarterly, at change of condition, and after a [redacted] Scoring: NJ Exec Order 26.4b1 [redacted] Further review of the above-provided documents for the NJ Exec Order 26.4b1 showed that it was not done after each [redacted] for Resident #109. On 5/30/24 at 11:49 AM, the [redacted] provided a timeline and interventions implemented. The timeline did not indicate what interventions were implemented after each [redacted]. The root cause analysis was not identified. On 5/30/24 at 1:18 PM, the survey team met with the facility's NJ Exec Order 26.4b1 [redacted]. The surveyor notified the facility management of the above findings and concerns. 2. On 5/21/24 at 9:53 AM, the surveyor observed Resident #89 in the unit day room in a wheelchair feeding themselves during breakfast. On 5/23/24 at 11:30 AM, the [redacted] provided the [redacted] Incident/Accident (I/A) report and stated that there were no other attachments such as statements and summary and conclusion to determine root cause analysis.	F 689		

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F 689	Continued From page 94 The surveyor reviewed the hybrid (combination of paper and electronic) medical records of Resident #89 as follows: According to the AR, Resident #89 was admitted to the facility with a diagnosis that included but was not limited to NJ Exec Order 26.4b1 [redacted] The resident's SCMDS with an ARD of [redacted] documented a BIMS score of [redacted] which reflected that the resident's cognitive status was [redacted] Section J Health Conditions showed that the resident had NJ Exec Order 26.4b1 . The personalized CP, initiated on NJ Exec Order 26.4b1 revealed a focus that Resident #89 was [redacted] for [redacted] related to a NJ Exec Order 26.4b1 , [redacted] The interventions included but were not limited to: a review of information on [redacted] and an attempt to determine the cause of [redacted] Record possible root causes; Alter remove any potential causes if possible; Educate resident/family/caregivers/IDT as to causes. Further review of the CP for falls included a focus on communication problems r/t NJ Exec Order 26.4b1 [redacted] which was created and revised on [redacted]	F 689		

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F 689	Continued From page 95	F 689		

The NJ Exec Order 26.4b1 reflected that Resident#89 was at a NJ Exec Order 26.4b1 with a score of NJ Exec

There were no further NJ Exec Order 26.4b1 assessments done after NJ Exec Order 26.4b1. The NJ Ex Order 26. NJ Exec Order 26.4b1 was to be completed on admission, quarterly, at change of condition, and after a NJ Exec O

A review of the resident's NJ Exec documentation revealed the following:

1. 02/09/24 at 02:50 PM. NJ Ex Order 26.4(b)(1) NJ Exec in resident's room with NJ Ex Order 26.4(b)(1). The investigation showed that NJ Exec Order 26.4b1 Resident #89 was NJ Exec Order 26.4b1 by the incoming nurse NJ Exec Order 26.4b1. Attached to the I/A report that was prepared by LPN#2 documented that the resident was NJ Exec Order 26.4b1 what had happened. The interventions added were NJ Ex Order 26.4(b)(1) assessments.

-The IDCP Notes were not completed to identify the root cause analysis.
-The I/A was incomplete. Did not have the name and statements from the incoming nurse.
-The NJ Exec CP included intervention to continue therapy as per plan of care initiated on NJ Exec Order 26.4b1

2. NJ Exec Order 26.4b1 in resident's NJ Exec Order 26.4b1. The I/A showed that the NJ Exec Order 26.4b1 resident was NJ Ex Order 2 by LPN#2 on NJ Ex Order 26.4(b)(1) next to NJ Ex Or and the resident NJ Ex Order 26.4(b)(1) what they NJ Ex Order 26.4(b)(1). The immediate interventions documented were a NJ Ex Order 26.4(b)(1) assessment, call bell within reach, and the resident was educated to call for help.

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 96 -The IDCP Notes dated [NJ Ex Order 26.4(] did not identify the root cause analysis. -The I/A was incomplete. It did not include statements from involved staff. -The [NJ Exec O]CP was not updated. A review of the 12 noon, [NJ Ex Order 26.4(] Progress Notes (PN) electronically signed by LPN#2 included that the resident was status [NJ Exec Order 26.4b1] and the 11-7 shift nurse reported to LPN#2 that Resident #89 complained of [NJ Exec Order 26.4b1] the physician was made aware and ordered to send to the hospital for further evaluation. The PN dated 3/10/24 at 7:30 PM documented by LPN#2 included that the resident returned from the hospital with a diagnosis of [NJ Exec Order 26.4b1] [redacted] was at the bedside. Further review of the above information, the facility failed to follow the CP interventions to review information on [NJ Ex Order 26.4(b)(1] and attempt to determine the [NJ Ex Order 26.4(b)(1)], record possible root causes and alter/remove any potential causes if possible. On 5/24/24 at 10:13 AM, the survey team met with the [U.S. FOIA (b)(6)] [redacted]. The surveyor notified the facility management of the above findings and concerns. The [NJ Exec Order 26.4b] stated that it was best practice to get all the information from involved staff, including their statements. The [U.S. FOIA (b)] stated that she did not write all the information needed in the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] incidents and that "I should have gone back and written in detail." The [U.S. FOIA (b)(6)] stated that they will review all incidents and make sure to complete them accordingly moving	F 689		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 689	Continued From page 97	F 689		

forward.

On 5/28/24 at 10:31 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] regarding I/A. The [U.S. FOIA (b)(6)] was unsure about the facility's policy and procedure with regard to the investigation of incidents.

On 5/29/24 at 10:15 AM, the [U.S. FOIA (b)(6)] provided a typewritten Investigation Summary and Conclusion dated [NJ Exec Order 26.4b1]. The [U.S. FOIA (b)(6)] informed the surveyor in the presence of the survey team that the Investigation Summary and Conclusion was done after the surveyor's inquiry. The [U.S. FOIA (b)(6)] stated that the facility team decided to meet on [U.S. FOIA (b)(6)] after the surveyor's inquiry, to re-evaluate the [U.S. FOIA (b)(6)] of the residents in order to know the root cause and analysis and identify appropriate interventions to prevent further [U.S. FOIA (b)].

At that same time, the [U.S. FOIA (b)(6)] stated that the facility team acknowledged that Resident #89's intervention to educate the resident to call for help was not an appropriate intervention for a [NJ Ex Order 26.4(b)(1)] resident. He further stated that the facility team acknowledged that [redacted] investigations with no statements of involved staff and a conclusion and summary was not initiated for [NJ Ex Order 26.4(b)(1)] I/A.

On 5/29/24 at 12:02 PM, the survey team met with the [U.S. FOIA (b)(6)]. The facility management did not provide additional information.

On 5/31/24 at 11:56 AM, during the facility exit conference of the survey team with the [U.S. FOIA (b)(6)] [redacted], and

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F 689	Continued From page 98 U.S. FOIA (b)(6), the facility management did not provide an additional information.	F 689		
F 725 SS=F	NJAC 8:39-27.1(a); 33.1(d) NJAC 8:39-27.1 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint #s NJ157563, NJ158377, NJ159018, NJ162913, NJ169759, and NJ173245	F 725	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS	7/15/24

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F 725	Continued From page 99 Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure residents' were provided with care to achieve their highest practical wellbeing by failing to a.) provide adequate staff to ensure effective supervision and documentation for residents with NJ Exec Order 26.4b1 (Resident #89 and #109) for two (2) of four (4) residents reviewed for NJ Exec Ord, and b.) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Refer to F689H 1.) On 5/21/24 at 9:53 AM, Surveyor #1 (S#1) observed Resident #89 in the unit day room in a wheelchair (w/c) eating breakfast. A review of the electronic medical record (eMR) revealed that Resident #89 had: NJ Exec Ord: NJ Exec Order 26.4b1 -Resident #89 was documented to have a Brief Interview for Mental Status (BIMS) score of U.S. PO which indicated NJ Exec Order 26.4b1 Surveyor #1 reviewed the Incident/Accident (I/A) reports provided by the facility. The reports included but were not limited to the following: Dated NJ Exec Order 26.4b1 . The investigation did not include all pertinent staff statements, left blank areas that should have been filled out, NJ Exec inspection report done asked	F 725	FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: II. " Refer to F689 Plan of correction " Resident #89 o Resident plan of care and interventions were reviewed by Director of Nursing and corporate team to ensure interventions in place for NJ Exec O are effective. o Staff members who NJ Exec Orde the resident NJ Exec Order 26.4b1 was identified and statement collected. o Summary and conclusion were completed and signed by the Director of Nursing and Administrator. o Incident reports for NJ Exec O on NJ Exec Order 26.4b1 were reviewed to ensure completion. o An investigation summary was conducted for Root Cause Analysis for mentioned NJ Exec O above. o Statements collected for incident on NJ Exec Order 26.4b1 . o Safety measures initiated: NJ Exec Order 26.4b and room NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 against sharp edges. o NJ Exec Order 26.4b will be maintained in NJ Exec Orde □ or activity area; refusal of NJ Exec Order 26.4b1 will be documented. o Offer NJ Exec Order 26.4b1 up upon rising, before meals, after meals and at bedtime. o Educate family/caregivers about safety reminders and what to do if a NJ Exec occurs. o	

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F 725	Continued From page 100 for NJ Exec Order 26.4b wearing of the resident at the time of NJ Exec and was left blank. Interventions added: NJ Ex Order 2 assessment. The report did not include a summary or conclusion and was not signed by the U.S. FOIA (b)(6) The facility did not identify the hazards and risks why the resident NJ Ex in order to implement interventions to reduce hazards and risk and modify the interventions when necessary when the resident was NJ Exec Order 26.4b1. Dated NJ Exec Order 26.4b1 Interventions added was left blank. Immediate interventions: NJ Ex Order 26.4(b)(1) assessment, call bell within reach, patient educated to call for help. NJ Exec inspection report done. List of immediate interventions: NJ Exec Order 26.4b1 assessment call bell within reach, patient educated to call for help. The report failed to identify the staff who found the resident NJ Exec Order 26.4b1. On 5/24/24 at 10:13 AM, in the presence of the survey team, the U.S. FOIA (b) stated that the U.S. FOIA (b)(6) who wrote the statement on NJ Ex Order 26.4(b)(1) was late and nurse who was administering medications was supposed to take of care of Resident #89. Surveyor #1 then asked the facility management, how the only nurse on that unit, at that time be assigned also perform resident care from 7 AM to 9 AM, and why there was no CNA assigned to the resident instead. The U.S. FOIA (b) stated that the two other CNAs were aware that they would take care of the resident even though they were not assigned. The surveyor also asked who were the two other CNAs and why there were no statements from them. The U.S. FOIA (b) was unable to state the names of the two other CNAs and stated that she had the	F 725	" Resident #109 o Resident plan of care and interventions were reviewed by Director of Nursing and corporate team to ensure interventions in place for NJ Exec O are effective. o Monitor NJ Exec Order 2 o NJ Exec Order 26.4b1 while awake o Safety measures: NJ Exec Order 26.4b1 and room NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 against sharp edges. o A root cause analysis was completed to ensure interventions used were effective. o Resident is no longer active in the facility. III. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents at have the potential to be affected by deficient practice. IV. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Administrator, Director of Nursing and Staffing Coordinator were educated by the corporate team on sufficient nursing staffing. " Facility□s Recruitment and Retention Strategies and Efforts have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 725	Continued From page 101 documentation. The U.S. FOIA (b) was unable to provide the documentation from the two CNAs for NJ Ex Order 26.4(b) incident. On that same date and time, Surveyor #1 then asked the U.S. FOIA (b) if the U.S. FOIA (b)(6) on NJ Exec Order 26.4b1 were complete investigations. The U.S. FOIA (b) stated, "I did not write all the information and I should have went back and wrote in details." On 5/29/24 at 10:15 AM, Surveyor #1 interviewed the U.S. FOIA (b)(6)) who provided a typewritten Investigation Summary and Conclusion dated NJ Exec Order 26.4b for the NJ Exec Order 26.4b1 The U.S. FOIA (b)(6) stated in the presence of the survey team that the Investigation Summary and Conclusion were completed after surveyor's inquiry. He stated the team decided to meet on NJ Exec Order 26.4b after surveyor's inquiry, to re-evaluate the NJ Exec Order 26.4b1 of the resident in order to know the root cause and analysis, identify appropriate interventions to prevent further NJ Exec because as the surveyor identified and questioned the NJ Exec intervention to remind the resident to call for help was not appropriate due to resident's NJ Exec Order 26.4b1 He further stated that the facility team acknowledged the surveyor's concern as well as the concern that the investigation had no statements and conclusion and summary for one NJ Exec incident. 2.) On 5/21/24 at 10:04 AM, Surveyor #2 observed Resident #109 sitting in their room. The surveyor observed a NJ Exec Order 26.4b1 . The resident was unable to be interviewed. On 5/22/24 at 10:43 AM, Surveyor #2 observed	F 725	referrals from current staff o Offer daily and weekend bonuses to attract overtime or Per Diem staff shifts o Regularly meet with Staff to boost morale o Conduct Staff Appreciation programs and activities to promote Staff Retention o Aggressively run ads in various social media platforms and employment application websites o Flexible shifts and schedules o Increased wages to be well above state minimum o Working with C.N.A. schools to recruit new grads o Contract with staffing agencies V. MONITORING OF CORRECTIVE ACTIONS: " The Director of Nursing will provide weekly reports to the Administrator regarding all efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the Corporate Director of Human Resources/Payroll. " Director of Human Resources/Payroll will submit monthly reports to the Quality Assurance committee X 3 months, documenting status of all recruitment and retention efforts. The Qulaity Assuarnce Committee will determine the need for further action plans.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 725	Continued From page 102 Resident #109 sitting in their room. On 5/23/24 at 8:40 AM, Surveyor #2 observed Resident #109 in bed resting. On 5/23/24 at 9:44 AM, Surveyor #2 observed Resident #109 in their room sitting in a w/c eating breakfast. A review of the eMR revealed that Resident #109 had multiple [redacted] as follows: U.S. FOIA (b)(6) [redacted] Resident #109 was documented to have a BIMS of NJ Exec Order 26.4b1 which indicated NJ Exec Order 26.4b1 [redacted] A review of the resident-centered on-going care plan included but was not limited to; interventions of educate the resident to ask for assistance, keep resident in supervised area as much as she will allow, ensure appropriate footwear when ambulating, review NJ Exec Order 26.4b1 and attempt to determine the cause, and supervision. On 5/28/24 at 11:08 AM, during an interview with Surveyor #2, the Licensed Practical Nurse (LPN) revealed that the resident was identified for NJ Exec Order 26.4b1. The LPN stated that the staff needed to monitor and keep Resident #109 close to the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 [redacted]. On 5/29/24 at 11:21 AM, Surveyor #2 called the family member (FM) regarding the resident and the falls. The FM stated that the resident was sent to the hospital for NJ Exec Orde of resident's NJ Exec Order 26.4b1 "The NJ Exec Order 26.4b1 [redacted]	F 725		

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F 725	Continued From page 103 The FM further stated that the resident was sent to the NJ Exec Order 26.4b1 [redacted].	F 725		

3.) On 5/31/24 at 8:26 AM, S#1 asked [redacted] to describe the Facility Assessment (FA) 3.2 and what it meant as stipulated in the FA the following: "Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Based on resident census and acuities, staffing is assigned to ensure there is sufficient staff to meet the needs of the residents at any time. Position Nurse aides, total number needed or average or range 39, licensed nurses providing direct care total number needed or average or range 19." The [redacted] responded that it meant that any given time, the facility was required to have total or average range of 39 CNA and 19 nurses.

On that same date and time, the [redacted] stated that he was aware of the staffing requirements and the New Jersey (NJ) mandated law. He further stated that he was aware that there were times that the facility was not meeting the requirements and the mandated law.

4.) Review of the NJ Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing as follows:

For the 2 weeks of staffing prior to survey from 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows:

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 725	Continued From page 104 -05/05/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/06/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/07/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/08/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/10/24 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. -05/12/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -05/13/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -05/14/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -05/15/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -05/16/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. -05/18/24 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. NJAC 8:39-4.1(a), 25.2(b), 27.1(a)	F 725		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		7/15/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 105 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility provided documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure, a.) expired supplies were identified and removed from active inventory, b.) maintain a system of medication (med) records that enabled to account the disposition and the prompt identification of potential NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) within the NJ Ex Order 26.4(b) box of a med cart, and c.) demonstrate periodic reconciliation of NJ Ex Order 26.4(b)(1) stored within the electronic back-up machine (EBM) was maintained.	F 755	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " The following expired items were removed and replenished from Emergency crash carts. o Five expired suction connecting tube with male connector. o Two expired Yankauer sunction handle. o Five expired non-conductive connecting tubing with two female connector. o Three expired suction catheter kit. " All nurses were educated re: the need	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 755	Continued From page 106 This deficient practice was identified for three (3) of six (6) medication carts, one (1) of one (1) med room, and one (1) of one (1) EBM, inspected for med storage and labeling. The evidence was as follows: 1.) On 5/29/24 at 9:57 AM, in the presence of the Registered Nurse (RN), the surveyor began the emergency crash cart inspection located in the dining area of the [NJ Exec] floor. At that time, the surveyor and the RN observed the following: 1. Two (2) suction connecting tube with male connector (used to evacuate fluid and debris from suction catheter or yankauer suction handle into a vacuum canister) that had an expiration date of 10/28/22 and 10/28/23. 2. One (1) yankauer suction handle (used to remove fluid and debris from a person's airway) had an expiration date of 5/2021. 3. Two (2) nonconductive connecting tubing with two (2) female connector (use to connect suction catheter and yankauer to suction sources to evacuate fluid and debris) that had an expiration date of 8/01/23. 4. Two (2) suction catheter kit (used to clear the airway of a person when unable to clear secretions on their own when airway is blocked, and breathing is difficult) that had expiration date of 02/02/2022. At 10:08 AM, the surveyor and the RN reviewed the Emergency Cart Check (emergency crash cart) accountability log of the [NJ Exec] floor which reflected the cart was checked and signed daily until May 29, 2024.	F 755	to check for expiration dates when checking the Crash Carts to ensure all items remain in date. " The Pharmacy was notified resident□s #77 [NJ Exec Order 26:4b] was poorly packaged. o The Director of Nursing/Designee counseled the nurses who failed to document the time and reason for the disposal for Resident #77□s [NJ Exec Order 26:4b] " The Narcotics in the EBM were reconciled without concerns. o All supervisors were educated re: the need to reconcile controlled substances in the EBM daily. " Residents were not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the same deficient practice. " All the Emergency Crash Carts were checked to identify any expired items. No discrepancies were identified. " All the narcotic declining sheets were checked to identify any discrepancies between the narcotic medication inventory and the declining inventory sheets. No discrepancies were identified. " EBM reconciled; no discrepancies were identified. " Residents were not affected by the deficient practice.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 755	Continued From page 107 At that time, during an interview with the surveyor, the RN stated the 11:00 PM to 7:00 AM nurse was responsible to ensure all items were in date and that the nurse probable missed the expired supplies. At that time, the RN acknowledged that expired supplies should have been removed and replaced. She would remove the identified expired items immediately, replenish the supplies and inform the US FOIA (b) (6)) of the concern. On 5/29/24 at 11:34 AM, in the presence of License Practical Nurse #1 (LPN #1), the surveyor began the emergency cart inspection located in the nurse's station of the NJ Elect floor. At that time, the surveyor and LPN #1 observed the following: 1. One (1) suction connecting tube with male connector that had an expiration date of 10/28/23. 2. One (1) yankauer suction handle had an expiration date of 5/2021. 3. One (1) nonconductive connecting tubing with two (2) female connector that had an expiration date of 8/01/23. At that time, the surveyor and LPN #1 reviewed the Emergency Cart Check accountability log for the 1st floor which reflected that the cart was checked and signed daily until May 29,2024. At that time, during an interview with the surveyor, LPN #1 stated the 11:00 PM to 7:00 AM, nurse was responsible to ensure all items on the emergency cart were up to date. LPN #1 acknowledged no expired items should be in the cart.	F 755	III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " All nurses were in-serviced on the need to properly inspect all items in the emergency crash carts. Emphasis was made on expiration dates. " All nurses were educated on proper documentation when disposing narcotics. Emphasis was made on time and reason for disposal. " All Nursing Supervisors were educated on the importance of proper documentation, i.e., the need to reconcile controlled substances in the EBM daily to maintain accurate accountability and reconciliation for controlled medications in the facility. IV. MONITORING OF CORRECTIVE ACTIONS: " DON or Designee will audit 3 emergency crash carts for 4 weeks and then 6 emergency crash carts Monthly x2 to ensure all items remain within expiration date. Audit Findings will be reported to t the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans. " The Unit Managers or designee will conduct audits of the Controlled Substance Declining Sheets on 3	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 755	Continued From page 108 At that time, LPN #1 stated she would dispose the expired items, replace, and inform the [U.S. FOIA (b)] of the concern. On 5/29/24 at 12:43 PM, in the presence of the [U.S. FOIA (b)(6)] the surveyor observed the following: 1. Two (2) suction connecting tube with male connector that had an expiration date of 10/2019, and 10/28/23. 2. Two (2) nonconductive connecting tubing with two (2) female connector that had an expiration date of 8/1/23. 3. One (1) suction catheter kit that had expiration date of 2/2/2022. At 12:48 PM, the [U.S. FOIA (b)] confirmed the items were expired, will dispose the meds, and inform the [U.S. FOIA (b)] 2.) On 5/29/24 at 10:33 AM, in the presence of LPN #2 the surveyor began the [NJ Ex Order 26.4(b)] med inspection, which was stored in a mounted, double locked portion of the med cart ([NJ Ex Order 26.4(b)] box). At 10:34 AM the surveyor and LPN #2 observed that [NJ Ex Order 26.4(b)(1)] Administration Record ([NJ Ex Order 26.4] for Resident 77's [NJ Exec Order 26.4b1] was wasted (disposed) five (5) times on [NJ Ex Order 26.4(b)(1)] without a documented time or reason for the disposal. At that time, LPN #2 could not locate the accountability explanation as to the reason why five (5) tablets (tabs) were wasted. The surveyor and LPN #2 did observe the disposition had two nurses' signatures.	F 755	units on a weekly basis x 4 weeks, then monthly there after x 2 months. Focus of the audits will be on ensuring that time and reason for any disposal of narcotics. Audit Findings will be reported to the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans. " The DON or designee will conduct audits of the electronic transaction journal on a weekly basis x 4 weeks, then monthly there after x 2 months. Focus of the audits will be on ensuring that daily reconciliation of the narcotic meds in the EBM. Audit Findings will be reported to the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 109	F 755		

A review of Resident #77's electronic Med Administration Record (eMAR) for NJ Exec Order 26.4b1 did not reflect refusals for the NJ Exec Order 26.4b1 [redacted].

3.) On 5/29/24 at 12:43 PM, the surveyor, LPN #3 and the U.S. FOIA (b)(6) could not locate the NJ Ex Order 26.4(b) log for the EBM.

At that time, during the cycle count conducted by LPN #3 and U.S. FOIA (b)(6), the surveyor and the staff observed a discrepancy for the NJ Exec Order 26.4b1 [redacted]) populated.

At that time, the U.S. FOIA (b)(6) did not know how to produce the discrepancy report from the EBM machine.

At that same time, the surveyor had not received the transaction log that reflected the date a NJ Ex Order 26.4(b) NJ Ex Order 26.4(b) med was removed, who removed the med, for which resident and the electronic log to reflect the shift-to-shift accountability report for the EBM.

On 5/29/24 at 12:52 PM, in the presence of the survey team, the U.S. FOIA (b)(6) [redacted] the surveyor discussed the concern regarding the expired supplies in the emergency carts and the med room, the potential for diversion reflected on the CDAR without documentation of the time disposed and the reason for the disposal for Resident #77's NJ Exec Order 26.4b1. The missing paper file for the reconciliation of the NJ Ex Order 26.4(b) meds in the EBM and the inability of the facility to produce

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 755	Continued From page 110 the electronic transaction journal that showed the periodic reconciliation of the [NJ Ex Order 26.4(b)] meds in the EBM for [NJ Ex Order 26.4(b)(1)]. On 5/30/23 at 10:29 AM, in the presence of the survey team, the [U.S. FOIA (b)(6)] stated that all the expired supplies have been replenished and acknowledged it should not have been there. At that time, the [U.S. FOIA (b)] submitted a picture of a text she had received from her staff dated [NJ Ex Order 26.4(b)(1)], informing her that they had wasted/disposed of five (5) tabs of Resident #77's [NJ Exec Order 26.4b1] due to poor packaging. No information was presented that the pharmacy was notified, and the [NJ Exec Order 26.4b1] that was poorly packaged was not returned to the pharmacy. At 12:02 PM, during the continuation meeting with the survey team, the [U.S. FOIA (b)(6)], and the [NJ Exec Order 26.4b1] stated that the 11:00 AM to 7:00 PM shift nurses should have performed the [NJ Ex Order 26.4(b)] reconciliation for the EBM machine. The [U.S. FOIA (b)] stated she had received the discrepancy report. The [U.S. FOIA (b)] admitted that she had not identified prior to surveyor inquiry that the periodic reconciliation of the narcotics for the EBM machine was not occurring. The expectation was that the nurse supervisor counted daily. Furthermore, the [U.S. FOIA (b)] stated that from that day forward the reconciliation would be signed and counted daily. A review of the provided facility policy Storage of Meds dated 5/01/24, included the following under Policy Interpretation and Implementation. 4. Drug containers that have missing incomplete,	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 111 improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals or returned to the dispensing pharmacy or destroyed. A review of the undated facility policy Controlled Substance Accountability included the following: -Have another nurse witness and co-sign the wasting of any dose of controlled drug. The reason for wasting should be documented. -Verify the expiration date of control substances in the back-up [EBM] daily or shift to shift cycle counts. NJAC 8:39-29.4 (g) (k),29.7(c)	F 755		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that all medications (meds) were administered without error of 5% or more. During the med observation conducted on 5/24/24, the two (2) surveyors observed five (5) nurses administer meds to six (6) residents. There were 30 opportunities, and three errors were observed which resulted in a med error rate of 10%. This deficient practice was	F 759	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Resident #31 o The Physician was notified of medication errors on [redacted]. o [redacted]s order timing was changed immediately to ensure medication is giving on an empty stomach. o [redacted] Powder order was	7/15/24

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F 759	Continued From page 112 identified for two (2) of six (6) residents (Residents #31 and #88), which was administered by two (2) of five (5) nurses. This deficient practice was evidenced by the following: According to the manufacturer's specifications for NJ Exec Order 26.4b1 included Administration Instructions to take before meals. 1. On 5/24/24 at 8:09 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare meds for Resident #31. The meds included an active physician's order (PO) dated NJ Ex Order 26.4(of the following: NJ Exec Order 26.4b1 give NJ Exec Order 26.4b1 by mouth one time a day for NJ Exec Order 26.4b1 and NJ Ex O . The order was plotted in the electronic Med Administration Record (eMAR) for 9 AM. NJ Exec Order 26.4b1 . The order was plotted in the eMAR for 7:30 AM. On that same date and time, the surveyor observed the LPN pour one (1) cap of NJ Exec Order 26.4b1 into a med cup (one ounce) for administration to Resident #31. The U.S. FOIA (b) did not read the cautionary in the bingo card (also known as blister packs, or bubble packs, are the most commonly used medication packaging in long-term care facilities) to take meds before a meal or as directed by your doctor.	F 759	discontinued. o Education was given to LPN regarding reading cautionaries before medication administration. o Resident was not adversely affected by the deficient practice. " Resident #88 o The physician was notified of potential medication error. o The nurse was given order by NJ Exec to administer medication whole in applesauce during the medication pass. o A cautionary was added to medication to be given whole in applesauce. o LPN was counseled to review cautionaries and bingo cards before medication administration. o Resident was not adversely affected by deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " Any resident currently with order for crushed medications, NJ Exec Order 26.4b1, NJ Exec Order 26.4b or any medications with extended release have the potential to be affected by the deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " All nurses were in-serviced on the need to maintain professional standards of clinical practice when following physician□s orders.	

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F 759	Continued From page 113 The LPN also poured [NJ Exec Order 26.4b1 redacted] At 8:14 AM, inside the resident's room, the LPN confirmed with the surveyor that she was ready to administer the resident's meds. Then, the surveyor stopped the med pass observation in the resident's room and asked the LPN to walk back to the med cart parked outside the resident's room. The surveyor asked the LPN how much water was in the plastic cup and to review the order again. At that same time, the LPN reviewed the eMAR and confirmed that the order for [NJ Exec Order 26.4b1 redacted] he LPN stated that the resident would complain if she filled up the cup with water. The surveyor observed the LPN fill the cup with ¾ water, proceeded inside the resident's room, and confirmed to the surveyor that she was ready to administer the meds. At 8:17 AM, the surveyor observed the [U.S. FOIA (b)(6) redacted]) inside the room deliver the resident's breakfast tray. The [redacted] and the LPN both repositioned the resident in the bed. The [redacted] set up the breakfast tray. At 8:26 AM, Resident #31 took a bite of food that was served by the [redacted]. The LPN then administered all meds ([NJ Exec Order 26.4b1 redacted]) whole with applesauce to the resident and the [redacted]. Afterward, the surveyor interviewed the LPN after the nurse signed the eMAR. The LPN informed the surveyor that she used an 8 oz cup of water	F 759	" All medication orders reviewed to ensure proper cautionaries are followed. " All residents with crushed medications orders will be reviewed to ensure the need to continue with order. " All nurses were educated on proper medication administration, medication preparation and reviewing cautionaries during medication administration. " Medication administration observations will continue monthly. IV. MONITORING OF CORRECTIVE ACTIONS: " The Director of Nursing or Pharmacy Consultant will continue to perform medication observations monthly to ensure nurses are competent with medication administration. Results will be reported to the Administrator. " The Director of Nursing or designee will review the physician orders for 10 residents for 3 months, to check medication are plotted according to cautionaries. " The pharmacy consultant will complete medication administration observation monthly on 2 nurses x 6 months. Medication administrations observations will be reported to the administrator. " Findings will be reported to the Director of Nursing and Administrator monthly and will be presented at the Quality Assurance Meeting . The Quality Assurance	

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F 759	Continued From page 114 to mix NJ Exec Order 26.4b1. The surveyor then asked the LPN to use a clean plastic cup to measure a med cup (one ounce) filled with water to determine how many ounces of the med cup could fill up the plastic cup. The LPN took a med cup and stated that the med cup was a one-ounce cup. The LPN filled up the med cup with water and transferred the water to a plastic cup and it filled the cup halfway. The LPN confirmed that the plastic cup she used for mixing the NJ Exec Order 26.4b was not an 8 oz cup and she was not sure how many ounces it was. At that same time, the LPN stated that she did not follow the PO for NJ Exec Order 26 to mix it with 8 oz of fluid. On 5/24/24 at 8:44 AM, the U.S. FOIA (b)(6) in the presence of the U.S. FOIA (b)(6) that she U.S. FOIA (b)(6) will get back to the surveyor to determine how many ounces were the plastic cup that the LPN was used in mixing one scoop of NJ Exec Order 26. On 5/24/24 at 10:11 AM, the U.S. FOIA (b) informed the surveyor that the plastic cup was a four-ounce cup. On 5/24/24 at 11:05 AM, the surveyor interviewed the LPN regarding NJ Exec Order 26.4b1. The LPN showed the bingo card of NJ Exec Order 26.4b1 and read the cautionary. The LPN stated that the med instruction meant to give the med 30 minutes before a meal. The surveyor then asked the LPN why she administered the med with the meal. The LPN responded that the resident wanted to eat. On 5/29/24 at 12:02 PM, the survey team met	F 759	Committee will determine the need for further audits and/or action plan.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 759		F 759		

Continued From page 115

with the U.S. FOIA (b)(6) . The surveyor discussed the above concerns and findings.

On 5/30/24 at 8:14 AM, the surveyor called and interviewed the U.S. FOIA (b)(6)) in the presence of the two surveyors. The surveyor asked about NJ Exec Order 26.4b1 on when to administer it. The U.S. FOIA informed the surveyor that it should be administered on an empty stomach around 6 AM or at least 30 minutes before meals. The surveyor asked what was the reason that it should be administered on an empty stomach, the U.S. FOIA responded that NJ Exec Order 26.4b1 was a NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) and that she usually puts that in her recommendation when she reviews MRR (Medication Record Review) monthly.

On that same date and time, the surveyor asked about the NJ Exec Order 26. The U.S. FOIA stated that NJ Exec Order 26 should be NJ Ex Order 26.4(b)(1) , a minimum of 4 oz. The surveyor then asked if the order was to mix with 8 oz of water what the nurse should do, the U.S. FOIA stated that the nurse should have followed the order.

At that same time, the surveyor notified the U.S. FOIA of the above findings and concerns. The U.S. FOIA stated it was wrong to administer NJ Exec Order 26.4b1 with meals, and if the U.S. FOIA was the one doing the med pass observation, it would be a med error.

A review of the facility's Med Administration Policy with a date of 5/01/24 that was provided by the U.S. FOIA (b) (6) included that meds are administered as prescribed in accordance with good nursing principles and practices. Meds are administered

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F 759	Continued From page 116 in accordance with the written orders of the attending physician. On 5/30/24 at 11:59 AM, the survey team met with the U.S. FOIA (b)(6) [redacted]. The U.S. FOIA (b) informed the surveyor that the new order for NJ Exec Order 26.4b1 was after the surveyor's inquiry. The U.S. FOIA (b) stated that the physician was notified of the concern regarding the NJ Exec Order 26.4b and advised the facility to talk to the U.S. FO. The U.S. FOIA (b) further stated that the U.S. FOIA was notified of the physician's information. According to the U.S. FOIA (b), the U.S. FOIA responded that NJ Exec Order 26 should be NJ Ex Order 26.4(b)(1) [redacted] At that same time, the U.S. FOIA (b)(6) stated that NJ Exec Order 26.4b1 should be given on an empty stomach. 2.) According to the manufacturer's specifications for NJ Exec Order 26.4b1 [redacted], Administration: NJ Exec Order 26.4b1 are scored and can be divided; however, do not crush or chew the whole or half tab. On 5/24/24 at 8:50 AM, two surveyors observed the Registered Nurse (RN) prepare meds for Resident #88. The meds included a PO for NJ Exec Order 26.4b1 [redacted]. At 8:59 AM, the surveyors observed the RN crush the meds, which she poured into a med cup that contained apple sauce, in preparation for administration to Resident #88 that included	F 759		

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F 759	Continued From page 117	F 759		

NJ Exec Order 26.4b1

At that time, the RN stated the resident had special instructions for med administration of crush meds.

At that time, the surveyor observed on the eMAR an annotation of crush meds.

At 9:01 AM, the RN confirmed she was ready to administer the crushed meds to Resident #88 and proceeded to walk towards the resident who was seated in the dining room.

At that time, in the presence of another surveyor, the surveyor, asked to speak with the RN, and walked back together to the med cart parked at the hallway.

At 9:02 AM, the surveyor asked the RN, could an NJ Exec Order 26.4b1 for Resident #88 be crushed. The RN stated "I am not sure" while reviewing the eMAR.

At 9:05 AM, the surveyor and the RN reviewed the bingo card for NJ Exec Order 26.4b1, together. The bingo card had an affixed cautionary label that indicated "Do not crush."

At that time, the RN was unsure of how to proceed with the med administration for Resident #88 and called the U.S. FOIA (b)(6) for the resident.

At that time, the RN stated she was instructed by the U.S. FO to administer the NJ Exec Order 26.4b1.

At 9:15 AM, the surveyors observed the RN dispose of the crushed meds into a liquid drug

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 759	Continued From page 118	F 759		

disposal system.

At 9:16 AM, the surveyors observed the RN prepare the meds for Resident #88 that included a whole tablet of [redacted] into applesauce.

At 9:21 AM, the surveyor asked the RN if the resident had an individualized care plan for the meds to be crushed. The RN was silent and had no response.

At 9:32 AM, during a telephonic interview with the surveyors, the [redacted] stated that [redacted] cannot be crushed or dissolved because of loss of efficacy.

The surveyor reviewed the medical record for Resident #88.

According to Resident #88's Admission Record (or face sheet, an admission summary) reflected that that resident was a long-term care (LTC) resident at the facility and had diagnoses which included but were not limited to [redacted]

A review of Resident #88s most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that Resident #88's cognition was [redacted]. The qMDS revealed the resident did not have a [redacted]

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 759	Continued From page 119 disorder and while a resident had a NJ Exec Order 26.4b1 [redacted] A review of the Order Summary Report for [redacted] did not reflect a PO to crush meds. A review of the Care Plan included a focus that the resident had a NJ Ex Order 26.4(b)(1) or potential for NJ Ex Order 26.4(b)(1) related to [redacted], initiated on [redacted]. The interventions included NJ Exec Order 26.4b1 initiated on [redacted]. On 5/29/24 at 12:02 PM, in the presence of the survey team, the U.S. FOIA (b)(6) [redacted] the surveyor discussed the concern regarding the med pass wherein the RN failed to review and adhere to the med cautionary displayed on the bingo card. On 5/30/24 at 12:02 PM, during a follow-up meeting with the survey team, the U.S. FOIA (b)(6) [redacted] acknowledged that the NJ Exec Order 26.4b1 should not have been crushed or dissolved, the physician should have been informed, and the PO should be followed. A review of the provided facility policy dated 5/01/24, included the following: Procedure: E. If it is safe to do so, med tabs may be crushed, or capsules emptied out when a resident has difficulty swallowing or is tub-fed [tube-fed] using the following guideline: a. Long acting or enteric coated dosage forms should generally not be crushed; an alternative should be sought. NJAC 8:39-11.2 (b), 29.2 (d)	F 759		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 790 SS=E	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that	F 790		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 790	Continued From page 121 led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records, it was determined that the facility failed to promptly, within three (3) days, refer Resident #88 for [redacted] services to replace the [redacted] which persisted for [redacted], and resulted in a [redacted] due to [redacted] This deficient practice was identified for one (1) of six (6) residents observed during medication (med) administration (Resident #88), and was evidenced by the following: On 5/24/24 at 8:59 AM, the surveyors observed the Registered Nurse (RN) crush the meds, which she poured into a med cup that contained apple sauce, in preparation for administration to Resident #88 that included [redacted] At that time, the RN stated the resident had special instructions for med administration of crush meds. At that same time, the surveyor observed on the [redacted] electronic Med Administration Record (eMAR) an annotation of crush meds. The surveyor reviewed the medical record for Resident #88. According to the Admission Record (or face sheet, an admission summary) reflected that resident was a long-term care (LTC) resident at the facility and had diagnoses which included but	F 790	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Resident #88 was referred to the [redacted]. " Resident was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents with dentures have the potential to be affected by the deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Missing item form was created to properly report any missing item including dentures. Facility wide education was provided on missing items process putting emphasis on completion of Missing item form with a focus on offering dental services when dentures are missing and documenting resolution. IV. MONITORING OF CORRECTIVE ACTIONS:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 790	Continued From page 122 were not limited to NJ Exec Order 26.4b1 [redacted] The most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that Resident #88's [redacted]. The qMDS revealed the resident did not have a NJ Exec Order 26.4b1 and while a resident had a NJ Exec Order 26.4b1 [redacted]. A review of the Care Plan (CP) included a focus that the resident had a NJ Ex Order 26.4(b)(1) or potential for NJ Ex Order 26.4(b)(1) related to [redacted], initiated on [redacted]. The interventions included NJ Exec Order 26.4b1 initiated on [redacted] Further review of the CP under special instructions revealed "Crushed Meds." A review of the resident's [redacted] Consultation dated [redacted] revealed that Resident #88 had his/her [redacted] inserted, and adjustment was made. Resident was to return for adjustment as needed. A review of Progress Notes (PN) for Resident #88 reflected the following: -On [redacted] at 10:58 PM, the nurse documented that the resident refused to NJ Exec Order 26.4b1	F 790	" The Director of SS or Designee will conduct up to 5 missing item form Audits weekly x 4 weeks, then 5 missing items form monthly x 3 months. Audits will focus on timely resolution of missing items. Results of audits will be reported to the Administrator monthly and presented in the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans for ongoing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 790	Continued From page 123 NJ Exec Order 26.4b1 despite the education given by the Certified Nursing Assistant (CNA). The resident NJ Exec Order 26.4b1. -On NJ Ex Order 26.4(at 3:53 PM, the nurse documented that the resident was received without NJ Exec Order 26.4b1 The staff looked through resident's room and belongings and was unable to locate the NJ Exec Order 26.4b1. All parties were made aware. -On NJ Ex Order 26.4(at 02:04 PM, the U.S. FOIA (b)(6) documented that the resident did not have any NJ Exec Order 26.4b1 . The resident was on the safest and NJ Exec Or . - On NJ Ex Order 26.4(b)(1 at 7:49 PM, the nurse documented that "the [responsible party] requested that the resident not having NJ Exec Order 26.4b1, found NJ Ex Order 26.4(b) ." An NJ Exec Or consult was completed. A new diet order was received: NJ Exec Order 26.4b1 . The nurse called the [responsible party] who did not answer. A review of the U.S. FOIA (b)(6) Evaluation and Plan of Treatment dated NJ Exec Order 26.4b1 to NJ Ex Order 26.4(b)(1, included the following: Current Referral: Reason for Referral/Current Illness: Patient was referred to skilled NJ Exec evaluation due to NJ Exec Order 26.4b1 Patient presented with NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1), and NJ Exec Order 26.4b1 . A review of the NJ Exec Or Discharge Recommendation dated U.S. FOIA (b)(6), included the following recommendations:	F 790		

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F 790	Continued From page 124 The diet recommended was NJ Exec Order 26.4b1. The liquid recommended was NJ Exec O liquids. NJ Exec Order 26.4b1 program were not indicated for the resident. A review of the Resident's NJ Ex Order 26.4(b)(1) reflected the following: [redacted] On 5/24/24 at 10:20 AM, during an interview with the surveyor, the SLP confirmed that the referral was due to Resident #88's NJ Exec Order 26.4b1. The US FOIA (b stated that since the resident was NJ Exec Order 26.4b1 without the NJ Exec Order 26.4b1, the resident's NJ Ex Or was changed to NJ Exec Order 26.4 At that time, the U.S. FOIA (b stated nursing was informed, and the kitchen was informed. At that same time, the U.S. FOIA (b)(6)) stated that they had to make sure the resident was safe, and when Resident #88 received his/her new NJ Exec Order 26.4b1 a re-evaluation can be done. Furthermore, the U.S. FOIA (b)(6) stated that he was part of the interdisciplinary team (a group of health care professionals from complementary fields	F 790		

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F 790	Continued From page 125	F 790		

who work together to treat a patient) and attended the meetings where the resident's recommendations were discussed.

On 5/28/24 at 10:39 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) stated that she had started NJ Exec Order 26.4b1 ago.

On that same date and time, the U.S. FOIA (b) explained to the surveyor that all residents, family member or nursing staff were able to report a missing item to her. The U.S. FOIA (b) stated that after an item was reported to her as lost, she documented the missing item into the Missing Items Report Log (MIRL) and directed the information to the corresponding department; As an example, hearing aids, glasses, and dentures, depending on the insurance we [the facility] would try to replace it.

At that time, the surveyor and the U.S. FOIA (b) reviewed the MIRL and did not find an entry for Resident #88's NJ Exec Order 26.4b1.

In addition, the surveyor and the U.S. FOIA (b) reviewed the Social Services PN from NJ Exec Order 26.4b1 which did not reflect a documentation that the facility had tried to replace Resident #88's NJ Exec Order 26.4b1 or reason for the delay of receiving NJ Exec Order 26 services.

On 5/29/24 at 12:52 PM, in the presence of the survey team, the U.S. FOIA (b)(6) the surveyor discussed the concern regarding the facility's failure to promptly, within three (3) days refer a

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F 790	Continued From page 126 resident with NJ Exec Order 26.4b1 and whose NJ Exec Order 26.4b1 was changed to NJ Exec Order 26.4 due to NJ Exec Order 26.4b1. The resident was NJ Exec Order 26.4b1 from NJ Exec Order 26.4b1 months to date. On 5/30/23 at 10:29 AM, in the presence of the survey team, the U.S. FOIA (b)(6) stated that when the NJ Exec Order 26.4b1 went missing the [responsible party] was informed and the [responsible party] wanted to take the resident to their own NJ Exec Order 26 but none of that was documented. On that same date and time, the NJ Exec Order 26 stated the other option was for the resident to see the in-house NJ Exec Order 26. The option was offered to the [responsible party] who agreed. At that time, the U.S. FOIA (b)(6) stated that their facility policy was three (3) days to follow-up. The U.S. FOIA (b)(6) acknowledged that it should have been done as prior to surveyor inquiry. A review of the provided facility policy, Dental Services dated 5/01/24, included the following under Procedure: 2. The facility will, if necessary or if requested, assist the resident: c. will promptly, within 3 days refer residents with list or damaged dentures for dental services.	F 790		
F 835 SS=F	NJAC 8:39-15.1 (b) (c) Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that	F 835		7/15/24

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F 835	Continued From page 127 enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records, and other facility provided documents, it was determined that the facility administration failed to ensure policies, procedures, and effective systems were implemented to maintain each resident's highest practicable physical, mental, and psychosocial well-being by failing to ensure a.) resident was free from the NJ Ex Order 26.4(b)(1), b.) a thorough investigation was completed for all NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) with history of NJ Ex Ord and NJ Ex Order 26.4(b)(1) c.) the physician was notified of the change in condition and the results of the NJ Exec Order in a timely manner, and d.) staffing levels were adequate to meet resident needs. This failure had the potential to affect all NJ Exec D residents who currently live in the facility. This deficient practice was evidenced by the following: Refer to: F600F, F607F, F610F, F684F, F689H, and F725F On 5/21/24 at 10:22 AM, the surveyor conducted an entrance conference with the U.S. FOIA (b)(6) The facility management informed the surveyor that the facility census (total number of residents) was NJ Exec D. On 5/23/24 at 12:30 PM, the surveyor interviewed	F 835	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " A thorough investigation was conducted to determine the origin of NJ Exec Order 26.4b1 for resident #6. " Statements were obtained from all staff/vendors involved in any allegation of NJ Exec Order 26 " Education was provided to NJ Exec Order 26.4b1 " Reviewed investigation for resident #42 and #85. " NJ Ex Order 26.4(b)(1) obtained for Resident #42 and #85. " PMD reviewed labs for resident #6. " Facility wide education includes vendors completed on investigating, preventing, and correcting alleged violations putting emphasis on investigating injuries of unknown origin, collecting statements, Interventions, and assessment documentation. " All nurses were re-educated to notify the physician and document the notification upon receiving any notification from the health alert system. " Refer to POC for F600F, F607F, F610F, F684F, F689H, F25F	

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F 835	Continued From page 128 the U.S. FOIA (b) about the concerns that were reported by Resident #6. The U.S. FOIA (b) stated that she was aware of the issue with the NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b) and an incident report was generated. The U.S. FOIA (b) added that she did not investigate the issue because she "knew what happened" and confirmed it was not reported to the New Jersey Department of Health (NJDOH) until after the surveyor's inquiry on NJ Exec Order 26.4b There was no investigation of the NJ Ex Order 26.4(b)(1) and it was not reported to the NJDOH until NJ Exec Order 26.4b The facility did not initiate an investigation even after the incident was reported on NJ Exec Order 26.4b1 The Certified Nursing Aide (CNA) was not asked to provide a statement regarding the incident. The NJ Exec Order 26.4b1 was not contacted and did not have a statement attached to the Incident/Accident (I/A) Report provided dated NJ Ex Order 26.4(b). There was no documented evidence that the NJ Exec Order 26.4b1 was educated as stated in the Interdisciplinary Notes dated NJ Exec Order 26.4b. On 5/23/24 at 12:50 PM, in the presence of the survey team, the U.S. FOIA (b) provided the I/A report dated NJ Exec Order 26 and stated that all she had. The U.S. FOIA (b) added that she knew what had happened, and the resident was NJ Ex Ord and NJ Ex Order 26.4(b)(1) that the NJ Ex Order 26.4(were obtained during the NJ Ex Order 2 of Resident #6. The U.S. FOIA (b)(6 stated that she did not have an investigation. There were no other employee statements from the prior three shifts included in the I/A report provided. The I/A report included the CNA statement who worked and reported the NJ Exec Order 26.4b1 There were no written statements obtained from the day shift staff involved with Resident #6's care.	F 835	II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the alleged deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were educated by the corporate team on the following: " Abuse prevention " Proper process to complete a thorough investigation on alleged abuse and falls " Proper notification on change in condition and results of blood work " Staffing level to meet resident needs " The administrator or designee will review all allegations of abuse for completion putting emphasis on statement collection, assessment documentation, and interventions. " The nursing supervisor/designee will print all laboratory reports for labs done daily and ensure that they are addressed daily. " The Director of Nursing/Designee will review all health alerts daily to ensure MD notification and follow up is completed " Refer to POC for F600F, F607F, F610F, F684F, F689H, F25F	

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F 835	Continued From page 129 On 5/28/24 at 10:31 AM, the surveyor interviewed the U.S. FOIA (b)(6) . The U.S. FOIA (b)(6) was unsure about the facility's policy and procedure with regard to the investigation of incidents. On 5/28/24 at 11:32 AM, the survey team met with the U.S. FOIA (b)(6) The surveyor asked if there was anything that was provided as guidance to staff regarding what was supposed to be completed when an NJ Ex Order 26.4(b)(1) occurred. At that time, when asked about the investigation related to Residents #85 and #42, the U.S. FOIA (b)(6) confirmed there were no other individual statements taken from any other residents. The U.S. FOIA (b)(6) then confirmed he did not review the investigation as he was not at the facility during that time. A review of the facility provided investigation revealed there were two statements attached, one untimed statement from the accused CNA, dated NJ Exec Order 26.4b, and another document with a typed statement, undated and untimed. There were no assessments, interviews from other staff, residents, facility management, or any of the alleged documents referenced per the incident, and there were no attached NJ Ex Order 26.4(b)(1) . The education for the CNA that was attached to the facility-provided investigation included a copy of an NJ Ex Order 26 policy from a completely different facility located in another town and did not have the same company name. On 5/28/24 at 11:50 AM, in the presence of the survey team, the surveyor asked the U.S. FOIA (b)(6) about who was responsible to ensure an investigation was completed and the U.S. FOIA (b)(6) confirmed that he	F 835	" Facility□s Recruitment and Retention Strategies and Efforts have been in progress, which include but are not limited to the following: " Offer Sign on bonuses to attract staff " Recruitment bonus to encourage referrals from current staff " Offer daily and weekend bonuses to attract overtime or Per Diem staff shifts " Regularly meet with Staff to boost morale " Conduct Staff Appreciation programs and activities to promote Staff Retention " Aggressively run ads in various social media platforms and employment application websites " Flexible shifts and schedules " Increased wages to be well above state minimum " Working with C.N.A. schools to recruit new grads " Contract with staffing agencies IV. MONITORING OF CORRECTIVE ACTIONS: " Director of Human Resources/Payroll will submit monthly reports to the Quality Assurance committee X 3 months, documenting status of all recruitment and retention efforts. The Quality Assurance Committee will determine the need for further action plans. " The Director of Nursing/Designee will audit 4 fall incidents weekly for 4 weeks to ensure	

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F 835	Continued From page 130 was responsible for the overall process and ensuring the statements were completed. On 5/29/24 at 9:15 AM, the surveyor interviewed the U.S. FOIA (b)(6)) in charge of Resident #6's care. The U.S. FOIA (b revealed that she was not made aware of the NJ Ex Order 26.4(b)(1)) work being done on NJ Exec Order 26.4b1. The U.S. FOIA (b was made aware of the NJ Exec Order 26.4b on and spoke with the nurse, who stated that the NJ Exec Order 26 were obtained during the NJ Exec being NJ Exec Order 26 On 5/30/24 at 11:59 AM, the survey team met with the U.S. FOIA (b)(6) The U.S. FOIA (b)(6) stated that the nurse should have called the doctor at that time. The U.S. FOIA (b)(6) stated "I know we should have done the whole investigation," and the statements but it was not done. On 5/30/31 at 01:15 PM, the facility management did not provide any rationale for not informing the physician of the change in condition for both residents. The U.S. FOIA (b) acknowledged that the nurse should have notified the physician regarding the NJ Ex Order 26.4(b)(result. On 5/31/24 at 8:09 AM, the surveyor interviewed the U.S. FOIA (b)(regarding the facility's Quality Assurance and Performance Improvement (QAPI). The surveyor discussed the concerns of the surveyors and asked the U.S. FOIA (b)(what areas in the surveyors identified concerns the facility was not able to identify from the facility's QAPI. The U.S. FOIA (b)(responded that the facility's investigation process was "basically" the more detailed documents process with proper outcome, how the facility investigated the incident, and who the facility spoke to.	F 835	compliance, then 4 fall incidents biweekly for 2 months. Findings will be reported to the Director of Nursing and administrator monthly and will be presented at the quarterly Quality Assurance Meeting.The Qulaity Assurance Committee will determine the need for further audits and/or action plan. " The Director of Nursing/Designee will audit 5 residents with lab draw, health alerts, and change in skin condition weekly x 4 weeks, then 5 residents bi-weekly for 2 months for compliance. Findings will be reported to the Director of Nursing and administrator monthly and will be presented at the quarterly Quality Assurance Meeting. The Qulaity Assurance Committee will determine the need for further audits and/or action plan. " Administrator or Designee will audit all Reportable weekly for 4 weeks and all reportable Monthly x2 to ensure proper investigation, prevention, and correction of alleged violation. " Audit Findings will be reported to the monthly and presented in the quarterly Quality Assurance Meeting. The Quality Assurance committee will determine the need for further audits and/or action plans. " All allegations of abuse and reportable events will be reviewed by the Quality Assurance Committee	

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F 835	Continued From page 131 At that same time, the surveyor asked the [redacted] were those areas identified as concerns by the surveyors were the facility's process and policy. The [redacted] stated, "Yes this is our process and policy and should have happened but did not happen." He further stated that he should know those policies and procedures and the I/A that happened. During the follow-up interview of the surveyor with the [redacted] on 5/31/24 at 8:26 AM, the [redacted] stated that he was aware of the requirement and NJ mandated law. He further stated that there were times when the facility was not meeting the requirements and the mandated law for staffing. The signed LNHA Job Description, dated 6/06/22 revealed: This position is responsible to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meets residents' needs in accordance with federal, state, and local regulations. Essential Requirements, Duties, and Responsibilities (included and were not limited to): Develop, maintain, and implement operational policies and procedures to meet residents' needs and compliance with federal, state, and local requirements. Determine the personnel requirements of the facility in collaboration with Department Managers and the Human Resource Department and hire or arrange for sufficient staff to provide sound resident care and implement the facility policies and procedures. Establish systems to enforce the facility policies and procedures.	F 835	quarterly to ensure continued compliance. " All allegations of abuse and reportable events will be reviewed by the Quality Assurance committee to ensure continued compliance. " Refer to POC for F600F, F607F, F610F, F684F, F689H, F25F	

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F 835	Continued From page 132 Supervise the recruitment, employment, performance, evaluation, promotion, and discharge of all staff in collaboration with the Human Resources Department. Inform appropriate agencies of changes in facility personnel as required. Assume the responsibility of reviewing and evaluating all recommendations of the facility's committee and consultants. Establish systems to ensure compliance with all federal, state, and local regulations. Observe all facility policies and procedures. A review of the facility's Abuse Investigation and Reporting Policy, dated 5/01/24 which revealed: Intent: 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. 3. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented.	F 835		

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F 835	Continued From page 133 NJAC 8:39- 5.1(a); 25.2(a)(b); 27.1(a); 33.1(d)(e)	F 835		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 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
F 880	Continued From page 134 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow appropriate hand hygiene practices during medication (med) administration and dining observation. This deficient practice was identified for two (2) of six (6) staff (one Licensed Practical Nurse and	F 880	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " The LPN was identified and immediately re-educated on proper hand hygiene and Infection control	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 880	Continued From page 135 Certified Nursing Aide #1) during med administration, and for two (2) of four (4) staff (CNA#2 and US FOIA (b) (6)) during dining observations according to facility's policy, practice, and Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24, included, Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient Before performing an aseptic task or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. Know how to wash hands with soap and water: Wet hands with water. Apply the manufacturer's recommended amount of product to your hands. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities recommend cleaning hands with soap and water for at least 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times and scrubbing hands and fingers with soap.	F 880	protocols. " CNA #1 was identified and immediately re-educated on proper hand hygiene, glove storage, and Infection control protocols. " CNA #2 and the US FOI were both identified and immediately re-educated on proper hand hygiene and Infection control protocols. " A general staff re-education was done on hand hygiene, glove storage and Infection Control Protocols II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the alleged deficient practice. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " Hand washing competencies will be conducted on all staff both direct care and non-direct care by the IP/Designee " All direct care staff were re-educated on proper storage of gloves and infection control protocols. " All direct care staff will be re-educated on hand hygiene with special attention to hand washing details and protocols, and following hand hygiene post doffing of PPE.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 880	Continued From page 136 1. On 5/24/24 at 8:17 AM, the surveyor observed the U.S. FOIA (b)(6) inside the room deliver Resident #31's breakfast tray. The Licensed Practical Nurse (LPN) asked Certified Nursing Aide #1 (CNA#1) who was also inside the room attending to the roommate of the resident to get a box of gloves outside the room. The LPN checked the resident's drawer and nightstand table for gloves and did not find gloves. CNA#1 at that time was wearing a pair of gloves, doffed off (removed) gloves, exit the room without performing hand hygiene. CNA#1 returned to the room with a box of gloves, donned (put on) a new pair of gloves without performing hand hygiene, and assisted the roommate with breakfast. LPN#1 also donned a new pair of gloves without performing hand hygiene after touching the resident's immediate [resident's nightstand table] environment. At that time, the U.S. FOIA and the LPN both repositioned Resident #31 in the bed. The U.S. FO set up the breakfast tray. On that same date and time, the surveyor in the presence of the LPN asked CNA#1 about the gloves stored inside the CNA uniform pocket. CNA#1 acknowledged that she was using them (gloves) during the resident's care. The LPN also acknowledged the surveyor's concern regarding CNA#1's hand hygiene and gloves inside the uniform pocket. The LPN stated that the CNA should not store gloves in her uniform pocket for infection control and should perform hand hygiene before and after gloves. At 8:26 AM, Resident #31 took a bite of food, and then the LPN administered all meds. The LPN	F 880	IV. MONITORING OF CORRECTIVE ACTIONS: " The IP/Designee will conduct 10 random hand washing competencies weekly for 1 month, then 5 random hand washing competencies bi-weekly for 2 months, with attention to hand washing post doffing of gloves. The audits will be presented quartely to The Quality Assurance Committee will determine the need for further audits and/or action plans for ongoing.	

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 880	Continued From page 137	F 880		

then performed handwashing for 22 seconds under the stream of running water. The surveyor notified the LPN of the concern regarding scrubbing her hands under a stream of running water and the LPN stated that she did not realize that she was scrubbing her hands under water and that she should have scrubbed her hands outside the water.

On 5/24/24 at 8:38 AM, the surveyor interviewed CNA#1 in the 2nd-floor dining area. The CNA informed the surveyor that she was an agency aide. The CNA stated that she should not store gloves inside her uniform pocket. She further stated that she should perform hand hygiene before and after using gloves and other PPE (personal protective equipment). The surveyor then asked the CNA why she stored gloves in her pocket and did not perform hand hygiene when the surveyor observed her in the resident's room above. The CNA responded that she was moving around and there were no gloves inside the room at that time.

On 5/24/24 at 8:53 AM, the surveyor interviewed the U.S. FOIA (b)(6) in the presence of another surveyor. The surveyor notified the U.S. FOIA (b)(6) of the above findings and concerns regarding CNA#1 and the LPN. The U.S. FOIA (b)(6) stated that regardless of the situation, the CNA and nurse should follow the facility's protocol and policy with hand hygiene and PPE use.

2. On 5/28/24 at 8:44 AM, the surveyor observed the U.S. FOIA (b)(6) provided hand wipes to all seven residents in the 3rd-floor day room and assisted all residents with their hand hygiene in preparation for breakfast. After the U.S. FOIA collected

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET DOVER, NJ 07801**

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F 880	Continued From page 138	F 880		

the used hand wipes, the [redacted] then went to the sink in the day room and performed handwashing. The [redacted] did not wet her hands after turning on the faucet, immediately scrubbed her hands for 26 seconds, then washed off the soap, dried her hands with paper towels, and discarded the used paper towels into the garbage.

Afterward, the surveyor interviewed the [redacted] regarding her handwashing. The [redacted] stated the above handwashing as the proper way of performing handwashing according to the education she received from the [redacted]. The [redacted] acknowledged and stated that she did not have to wet her hands prior to applying soap and when scrubbing her hands.

On that same date at 8:50 AM, the surveyor observed CNA#2 in the 3rd-floor day room assisting the [redacted]. CNA#2 performed handwashing for 8 (eight) seconds. During an interview of the surveyor with CNA#2, CNA#2 stated that handwashing should be at least 20 seconds according to the education and in-service she received from the [redacted] and the previous [redacted]. The surveyor asked the CNA if she scrubbed her hands for 20 seconds and she stated "Maybe I did it fast." The surveyor then notified the CNA of the concern that she scrubbed her hands for 8 seconds. The CNA acknowledged that she felt the same way that it was not 20 seconds.

On 5/28/24 at 8:55 AM, the surveyor interviewed the [redacted] in the 3rd-floor unit near the day room in the presence of another surveyor. The surveyor notified the [redacted] of the above findings and concerns regarding [redacted] and CNA#2 about

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 139 handwashing. The [redacted] stated that it was not appropriate what the CNA and the [redacted] performed during handwashing and will re-educate both staff about proper handwashing to wet hands first and it should be done for at least 20 seconds the hand scrubbing. On 5/29/24 at 12:02 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] The surveyor discussed the above concerns regarding hand hygiene. A review of the facility's Handwashing/Hand Hygiene Policy with a review date of 5/01/24 that was provided by the VPoCS included that the facility considers hand hygiene the primary means to prevent the spread of infections. Use an ABHR; or, alternatively, soap and water for the following situations: before and after direct contact with residents; before donning gloves; before moving from a contaminated body site to a clean body site during resident care; after removing PPE; before and after handling food; and before and after assisting a resident with meals. Washing hands: wet hands first with water, then apply an amount of product recommended by the manufacturer to hands, rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers .... On 5/30/24 at 11:59 AM, the survey team met with the U.S. FOIA (b)(6) [redacted]. There was no further information provided by the facility management. NJAC 8:39-19.4(a)(1)	F 880		

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	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility provided documentation, it was determined that the facility failed to ensure that the employed designated U.S. FOIA (b)(6) had completed specialized training in infection prevention and control per Centers for Medicare & Medicaid Services (CMS) guidance prior to assuming the U.S. FO role for one (1) of one (1) employee reviewed for U.S. FO This deficient practice was evidenced by the following: On 5/23/24 at 11:28 AM, the surveyor interviewed the U.S. F who stated that he started as the facility's U.S. F on NJ Exec Order 26.4b1. He added that he started the specialized training after he started as the	F 882	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " Infection Preventionist is currently in place at the facility with specialized training and certification effective NJ Exec Order 26.4. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: " All residents have the potential to be affected by the alleged deficient practice.	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 882	Continued From page 141 facility's [redacted] On 5/24/24 at 8:14 AM, the surveyor reviewed the facility provided signed job description for the [redacted] which was dated [redacted]. The surveyor then reviewed the facility provided specialized training certificate which had a completion date of [redacted]. The [redacted] did not have the specialized training prior to assumption of the [redacted] role. On 5/24/24 at 9:25 AM, the surveyor interviewed the U.S. FOIA (b)(6) [redacted] and the U.S. FOIA (b)(6) [redacted] and they confirmed that the date when the [redacted] signed the job description was when he assumed the [redacted] role. On 5/24/24 at 10:13 AM, in the presence of the survey team, the surveyor notified the [redacted], U.S. FOIA (b)(6) [redacted] and [redacted] the concern that the [redacted] did not have specialized training prior to assuming the role of [redacted]. The [redacted] stated that the [redacted] was in training with the prior [redacted] at first. The surveyor asked the facility administration when the last day of the prior [redacted] was. On 5/24/24 at 11:12 AM, in the presence of the survey team, the [redacted] stated that the prior [redacted] last day was approximately [redacted] and that the [redacted] was only under training with the prior [redacted] for part of the time. The [redacted] confirmed that the [redacted] had assumed the [redacted] role prior to finishing the specialized training. She added that she was going to change the job description. A review of the facility provided IP job description, dated 11/07/2022, included the following: Intent: Facilities will assign an individual meeting	F 882	III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR: " The facility will notify the DOH and request a waiver in the event of losing the current IP and are unable to hire an individual meeting the qualifications despite good faith efforts to do so. " The US FOIA (b) (6) [redacted] were educated on Proper IP requirements focusing on completion of specialized training prior to assuming the IP role. " The Director of Nursing and/or designee will ensure that infection prevention measures are being met utilizing the guidelines from CMS and the CDC prior to assuming the role. IV. MONITORING OF CORRECTIVE ACTIONS: " The Quality Assurance Committee will review the IP qualifications quarterly and determine the need for further audits and/or action plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING _____ B. WING _____	C 05/31/2024

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

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F 882	Continued From page 142 the qualifications listed below as the facility IP. In the event the facility cannot recruit and fire an individual that meets the required qualifications, despite good faith efforts to do so, the facility will notify the DOH and request a waiver. The facility may assign/hire an individual with relevant experience and good potential for the IP role. This individual will receive appropriate orientation and training, and be mentored by an experienced IP ... If an individual is identified with good potential and relevant experience, the IP assigned will complete the online infection prevention course through the Centers for Disease Control Prevention during the orientation process, if they have not already completed it. N.J.A.C. 8:39-19.1(b)	F 882		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	C 05/31/2024

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

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S 000	Initial Comments Complaint #s: NJ#157563, #158377, #159018, #162913, #164582, #165792, #169759, #171067, #171307, #173245 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint #s NJ157563, NJ158377, NJ159018, NJ162913, NJ169759, and NJ173245 Based on observation, interviews, and pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey and failed to notify the Clearing House Coordinator when a Certified Nurse Aide was accused of NJ Exec Order 26.4b1 and and the staffing agency placed on a "Do Not	S 560	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: " The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to fill the shift. " Recruitment efforts by the facility to hire CNA□s, direct nursing staff include the following:	6/14/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	C 05/31/2024

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

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S 560	Continued From page 1 Return" list. This deficient practice was evidenced by the following: PART A Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, "indicated the New Jersey Governor signed into law P.L. 2020c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no few than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 06/12/2022 to 06/25/2022, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -06/12/22 had 13 CNAs for 120 residents on the day shift, required at least 15 CNAs. -06/16/22 had 15 CNAs for 127 residents on the	S 560	Aggressively running ads through various social media platforms; Utilization of employment application websites; and fostering partnerships with recruitment and employment agencies. " A report was submitted to the Clearing House Coordinator in regard to Certified Nurse Aide being accused of NJ Exec Order 26.4b1. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this situation. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR " Administrator, Director of Nursing and Staffing Coordinator were educated by the corporate team on sufficient nursing staffing. " Administrator and Director of Nursing were educated by the corporate team on proper reporting to the Clearing House. " Facility□s Recruitment and Retention Strategies and Efforts have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Offer daily and weekend bonuses to attract overtime or PRN staff shifts o Regularly meet with Staff to boost morale	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	C 05/31/2024

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EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 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) COMPLETE DATE
S 560	Continued From page 2 day shift, required at least 16 CNAs. 2. For the 5 weeks of Complaint staffing from 08/14/2022 to 09/17/2022, the facility was deficient in CNA staffing for residents on 14 of 35 day shifts as follows: -08/14/22 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -08/21/22 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -08/22/22 had 4 CNAs for 125 residents on the day shift, required at least 16 CNAs. Note, this represents less than half of the minimum required CNAs. -08/24/22 had 7 CNAs for 124 residents on the day shift, required at least 15 CNAs. Note, this represents less than half of the minimum required CNAs. -08/28/22 had 14 CNAs for 123 residents on the day shift, required at least 15 CNAs. -09/01/22 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -09/05/22 had 15 CNAs for 129 residents on the day shift, required at least 16 CNAs. -09/06/22 had 15 CNAs for 129 residents on the day shift, required at least 16 CNAs. -09/07/22 had 15 CNAs for 136 residents on the day shift, required at least 17 CNAs. -09/08/22 had 14 CNAs for 134 residents on the day shift, required at least 17 CNAs. -09/09/22 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -09/10/22 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. -09/11/22 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -09/12/22 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. 3. For the 2 weeks of Complaint staffing from	S 560	o Conduct Staff Appreciation programs and activities to promote Staff Retention o Aggressively run ads in various social media platforms and employment application websites o Flexible shifts and schedules o Increased wages to be well above state minimum o Working with C.N.A. schools to recruit new grads o Contract with staffing agencies IV. MONITORING OF CORRECTIVE ACTIONS " Director of Human Resources/Payroll will submit monthly reports to the Quality Assurance Committee X 3 months, documenting status of all recruitment and retention efforts. The Quality Assurance Committee will determine the need for further action plans. " Director of Human Resources will submit monthly reports to the Quality Assurance Committee X 3 months, documenting reasoning for employee termination and if report to the clearing house was necessary. The Quality Assurance Committee will determine the need for further action plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	C 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 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) COMPLETE DATE
S 560	Continued From page 3 10/09/2022 to 10/22/2022, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -10/16/22 had 14 CNAs for 135 residents on the day shift, required at least 17 CNAs. -10/17/22 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -10/21/22 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs. 4. For the 2 weeks of Complaint staffing from 03/12/2023 to 03/25/2023, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -03/25/23 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. 5. For the 2 weeks of Complaint staffing from 07/09/2023 to 07/22/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/09/23 had 15 CNAs for 135 residents on the day shift, required at least 17 CNAs. -07/16/23 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. 6. For the 2 weeks of Complaint staffing from 04/14/2024 to 04/27/2024, the facility was deficient in CNA staffing for residents on 9 of 14 day shifts as follows: -04/16/24 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/18/24 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/19/24 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/20/24 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/21/24 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061423	A. BUILDING: _____ B. WING _____	C 05/31/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 -04/22/24 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/25/24 had 15 CNAs for 130 residents on the day shift, required at least 16 CNAs. -04/26/24 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -04/27/24 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. 7. For the 2 weeks of staffing prior to survey from 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -05/05/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/06/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/07/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/08/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -05/10/24 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs. -05/12/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -05/13/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -05/14/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -05/15/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. -05/16/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs. -05/18/24 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. On 5/21/24 at 10:26 AM, during tour of the facility, an unsampled resident was observed lying in bed awake and [NJ Exec Ord] wearing a [NJ Exec Order 26.4b1]. The resident stated that staffing was short, "I am still	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 5 in bed. Not the staff's fault but we have [NJ Exec Order 26.] residents on the unit and not enough CNA's. I go to [NJ Exec Order 26.] and prefer to have [NJ Exec Order 26.] in the morning. As you can see I'm still in bed." On 5/29/24 at 9:41 AM, the Director of Nursing (DON) stated that the CNA staffing expectations were that on the day shift 8 residents to1 CNA, on the evening shift 10 residents to 1 CNA, and on the night shift she was not sure what the CNA staffing should be. The DON stated she did not do the staffing or the assignments. On 5/29/24 at 9:50 AM, the Staffing Coordinator (SC) stated the ratios were on the day shift 1 CNA for 8 residents, on the evening shift 1 CNA for 10 residents and on the night shift 1 CNA to 14 residents. The SC stated there were call outs and "we try best to fill the empty spots." When inquired if she felt the facility was short CNAs at times, the SC stated, "No. We take assistance from the agencies." The SC further stated, "sometimes yes and I try my best." On 5/31/24 at 8:26 AM, the Licensed Nursing Home Administrator (LNHA) was asked to describe the Facility Assessment according to "3.2 Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Based on resident census and acuities, staffing is assigned to ensure there is sufficient staff to meet the needs of the residents at any time. Position Nurse aides, total number needed or average or range 39, licensed nurses providing direct care total number needed or average or range 19." The LNHA stated that on any given day the above	S 560		

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S 560	Continued From page 6 ratio of CNA and nurses should be followed. The LNHA stated that the facility followed the New Jersey mandate for staffing ratios and that he was aware that there were times that the facility was not meeting the requirements. PART B 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;	S 560		

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S 560	Continued From page 7 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 5/21/24 at 10:22 AM, the surveyor conducted and entrance conference with the Vice President of Clinical Services (VPoCS), Director of Nursing (DON), LNHA and in the presence of another surveyor. The facility was asked if there were any staff terminated in the past six months for care related concerns. The DON and LNHA stated there were none. On 5/28/24 at 11:20 AM (Resident #85) and 01:01 PM (Resident # 42), the Vice President for Risk Management (VPoRM) provided copies of two [redacted] which he obtained from the [redacted]. The reports both revealed the DON reported the [redacted] on [redacted]. The Investigation Report for Resident #42 detailed a narrative and the [redacted] interviewed the resident (DON not indicated as present for this interview as documented in the summary) and the report documented ... the CNA escorted the resident to [redacted], began to [redacted]] Resident #85 ...The narrative for Resident #42 documented ... that after the resident heard the account being [redacted] by Resident #85, he/she informed the staff the he/she was [redacted] on [redacted] by the same CNA (DON not indicated as present for this interview as documented in the summary) ... Resident #42 was [redacted] by the CNA, [redacted], and [redacted] and then told the CNA [redacted] ...	S 560		

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S 560	Continued From page 8 On 5/28/24 at 02:15 PM, the LNHA provided the surveyor with an email that indicted the accused CNA was placed on a "Do Not Return" list due to [NJ Exec Order 2] allegations. On 5/29/24 at 8:26 AM, the survey team met with the LNHA, DON, VPoCS and VPoRM about the concerns regarding the investigation and concerns related to the allegations of [NJ Exec Order 2] [redacted] by a CNA. The surveyor asked if the facility reported the CNA to the Clearing House and the facility was unable to provide any documentation regarding the Clearing House notification.	S 560		
S2120	8:39-31.1(c) Mandatory Physical Environment (c) Fire safety maintenance and retrofit of long-term care facilities shall comply with the Uniform Fire Safety Code (N.J.A.C. 5:18) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Fire Safety Code may be obtained from the Fire Safety Element of the Department of Community Affairs, P.O. Box 809, Trenton, New Jersey 08625-0809.	S2120		6/25/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2120	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 5/23/24 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that quarterly uniform fire code inspections were conducted in accordance with N.J.A.C.5:70-2.5 for three (3) of four (4) quarters. This deficient practice had the potential to affect all 148 residents and was evidenced by: A review of the facilities uniform fire code inspection reports for the previous 12 months revealed only one inspection was conducted. This inspection was dated 4/17/24. In an interview at 01:00 PM the MD confirmed the findings and could not provide any further documentation. The MD was informed of the deficient practice at the Life Safety Code exit conference on 5/28/24.	S2120	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The facility MD contacted local Fire Department for a to timely complete quarterly uniform code inspections are conducted in accordance with N.J.A.C 5:70-2.5. Inspection is scheduled for the week of 6/25/24 . 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents, staff and visitors have the potential to be affected by the deficient practice. The Director of Maintenance will ensure that the facility is timely complaint with quarterly uniform code inspections are conducted in accordance with N.J.A.C 5:70-2.5. Software program implementation initiated as of 5/19/2024 to ensure all maintenance needs and repairs are tracked and completed in a timely manner 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2120	Continued From page 10	S2120	¿ Administrator educated the Maintenance Staff regarding the following: To comply with quarterly uniform code inspections are conducted in accordance with N.J.A.C 5:70-2.5 as required and to develop an auditing tool to keep track of timely inspections The administrator will ensure implementation of software program to ensure all work orders are completed in a timely manner. Audit tool will be developed to ensure compliance 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee will conduct monthly audits to ensure that Compliancy with quarterly uniform code inspections is conducted in accordance with N.J.A.C 5:70- 2.5 Completed Audits Logs will be submitted to the Administrator monthly x 6 months. Quarterly Quality Assurnace Committee will determine the need for further action plan(s) to ensure on-going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S2120	Continued From page 11	S2120	compliance.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315355 Y1	A. Building B. Wing Y2	7/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0584	Correction	ID Prefix	F0600	Correction	ID Prefix	F0607	Correction
Reg. #	483.10(i)(1)-(7)	Completed	Reg. #	483.12(a)(1)	Completed	Reg. #	483.12(b)(1)-(5)(ii)(iii)	Completed
LSC		07/15/2024	LSC		07/15/2024	LSC		07/15/2024
ID Prefix	F0609	Correction	ID Prefix	F0610	Correction	ID Prefix	F0641	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.12(c)(2)-(4)	Completed	Reg. #	483.20(g)	Completed
LSC		07/15/2024	LSC		07/15/2024	LSC		07/15/2024
ID Prefix	F0657	Correction	ID Prefix	F0658	Correction	ID Prefix	F0684	Correction
Reg. #	483.21(b)(2)(i)-(iii)	Completed	Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.25	Completed
LSC		07/15/2024	LSC		07/15/2024	LSC		07/15/2024
ID Prefix	F0689	Correction	ID Prefix	F0725	Correction	ID Prefix	F0755	Correction
Reg. #	483.25(d)(1)(2)	Completed	Reg. #	483.35(a)(1)(2)	Completed	Reg. #	483.45(a)(b)(1)-(3)	Completed
LSC		07/15/2024	LSC		07/15/2024	LSC		07/15/2024
ID Prefix	F0759	Correction	ID Prefix	F0790	Correction	ID Prefix	F0835	Correction
Reg. #	483.45(f)(1)	Completed	Reg. #	483.55(a)(1)-(5)	Completed	Reg. #	483.70	Completed
LSC		07/15/2024	LSC		07/15/2024	LSC		07/15/2024

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315355 Y1	A. Building B. Wing Y2	7/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix F0882	Correction		
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(b)(1)-(4)	Completed		
LSC	07/15/2024	LSC	07/15/2024		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
5/31/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061423 Y1	A. Building B. Wing Y2	7/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix S2120	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-31.1(c)	Completed	Reg. #	Completed
LSC	06/14/2024	LSC	06/25/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET** **DOVER, NJ 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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 5/23/24, 5/24/24 and 5/28/24, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The LTC facility is an existing 6-story building with a basement that was built in 90's, with a 2-story addition. It is composed of Type II unprotected construction. The facility is divided into 10- smoke zones. The generator does approximately 50% of the building as per the U.S. FOIA (b)(6). The diesel generator is located outside the facility and has an interior shutoff located in the basement. The facility has 155 certified beds. At the time of the survey the census was 148.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered	K 161		12/31/25

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

Electronically Signed | 06/24/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 161	Continued From page 1 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 5/23/24, in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to provide an acceptable construction type and construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through 19.1.6.7, 19.3.1 and 8.6. This deficient practice was identified for 4 of 6 accessible building observations and evidenced	K 161	)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a) The facility was granted a Time Limited Waiver by CMS on 9/16/22. The time frame to complete the repairs in addressing all areas to achieve the required 2-hour fire protection is	

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K 161	Continued From page 2 by the following: 1. On 5/23/24, during the building tour at 12:20 PM, the surveyor in the presence of the US FOIA (b) (6)), observed on floor #6, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. 2. On 5/23/24, during the building tour at 12:50 PM, the surveyor in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6)) observed on floor #5, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. 3. On 5/23/24, during the building tour at 1:30 PM, the surveyor in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) observed on floor #4, that when the ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. 4. On 5/23/24, during the building tour at 2:10 PM, the surveyor in the presence of the U.S. FOIA (b)(6)) and U.S. FOIA (b)(6) observed on floor #3, that when the	K 161	estimated to exceed the required 60 days to comply. The facility hired a contractor to provide scope of work for repair/replacement of the missing fire protection on the unprotected structural steel beams visible above the ceiling. Completion date for construction of work related to this waiver would be 12/31/2025. b) To mitigate the current situation and to ensure the safety of the residents/staff /visitors, the Director of Maintenance or designee will conduct monthly in-services to all staff on life saving strategies that focus on fire prevention and resident transfer techniques. The Director of Maintenance will also ensure that monthly fire drills are conducted. c) No residents, staff or visitors were directly affected by this deficient practice. 2)How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? a)All residents, staff and visitors have the potential to be affected by the deficient practice. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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K 161	Continued From page 3 ceiling tiles were removed on both sides of the 2-hour barrier from the old section of the building to the new section of the building, it was observed that the beam, metal box truss and supporting corrugated steel decking were all unprotected with no fire resistant rating provided. On 5/23/24, at approximately 1:10 PM, the surveyor conducted an interview with the U.S. FOIA (b)(6). The surveyor requested a set of building plans identifying the metal deck was restrained or unrestrained, UL assembly and fire resistance rating for the steel beams and composite metal corrugated deck. At that time, no documents and/or drawings were provided. The U.S. FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e) * This deficient practice was cited in 5/2/22 and the completion date for the construction of work related to this waiver is required by 12/31/25.	K 161	a)The facility received CMS approval on 9/16/22 for a Time Limited Waiver and hired a contractor to provide scope of work for repair/replacement of the missing fire protection on the unprotected structural steel beams visible above the ceiling. Completion date for construction of work related to this waiver would be 12/31/2025. b) The facility has implemented a monthly fire safety inspection form to be completed by the Director of Maintenance or designee to ensure that all fire safety systems such as ceiling systems, door closers and penetrations are in full operational condition. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: 4a)The Director of Environmental Services or Designee will conduct monthly audits until completion of all work related to the tag to assess continued fire safety requirements. Audit findings will be presented monthly to the QAPI Committee on a monthly basis for evaluation and follow up while the waiver is active. 4b)Until the completion of the construction of work related to this waiver, the Administrator or Designee will conduct the following monthly audits to ensure that the residents/staff/visitors are kept safe:	

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K 161	Continued From page 4	K 161	(a) Review Sign-in sheets to ensure that monthly in-services to all staff are completed on life saving strategies that focus on fire prevention and resident transfer techniques (b)Review evidence of completion of monthly fire drills; and (c) Review of completed monthly fire safety inspection form to ensure that Director of Maintenance or Designee checked all fire safety systems (such as ceiling systems, door closers and penetrations) to ensure that they are in full operational condition. Findings of the above audits will be reported to the QAPI Committee on a monthly basis and will be incorporated in the Facility s QAPI Program.	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/28/2024 in the presence of facility management, the facility failed to ensure an exit discharge was free from obstructions in	K 211	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	6/14/24

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K 211	Continued From page 5 accordance with NFPA 101:2012 edition Section 7.1.10.1 This deficient practice had the potential to affect all residents in 2B wing and was evidenced by the following: An observation at 1:00 PM revealed that the exit discharge stairs from the exit stairway at the end of 2B wing to the parking lot was obstructed by an electric hospital bed preventing exit discharge. In an interview at the time, the U.S. FOIA (b)(6) confirmed the obstructions and stated that the bed was put there to be worked on. The facility U.S. FOIA (b)(6) was informed of the deficient practices at the survey exit at 10:30 AM. NJAC 8:39-31.2(e)	K 211	(a) The electrical hospital bed, which was being repaired near a resident room for safety care, was removed to ensure it didn□t obstruct exit preventing exit discharge by the 2B wing to the parking lot 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who have the potential to be affected by the deficient practice. There were no residents affected by this situation. The hospital bed was removed. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? The Maintenance staff was in-service not to repair beds in the hallway and to maintain means of egress free. An audit was conducted throughout the facility to ensure that there were no other obstructions of egress. Maintenance Director or designee will complete a weekly observation rounding audit tool to ensure no obstruction to the means of egress. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	

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K 211	Continued From page 6	K 211	The Administrator or designee will audit exit doors weekly x 4 weeks and then monthly x 3 months, to ensure that means of Egress are not blocked. Findings will be submitted to the QAPI Committee monthly and will be incorporated in the Facility QAPI Program to ensure on-going compliance. QAPI committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 252 SS=F	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on interview and observation, in the presence of the facility's U.S. FOIA (b) (6) [redacted] on 5/28/24, it was determined that the facility failed to ensure that exits did not pass through an intervening room in accordance with NFPA 101-2012 edition Life Safety Code sections 7.4 and 7.5 and 19.2.5.4. This deficient practice was identified in 1 of 2 exits and could affect 80 residents residing in the facility as evidenced by the following:	K 252	I. TIME-LIMITED WAIVER REQUEST K-252: SS = F Number of Exits - Corridors CFR(s): NFPA 101 1) Facility is seeking a time-limited waiver for the following to ensure compliance A Time Limited waiver is being	12/31/24

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K 252	Continued From page 7 During a tour of the building on 5/28/24, the surveyor in the presence of the U.S. FOIA (b)(6) observed 1 of 2 of exits located on floors 3 through 6 that passed through the Dayroom/Dining room, not directly to the exit stairway. This deficient practice was acknowledge by the U.S. FOIA (b)(6) during the tour and verbally conveyed to him during the Life Safety Code survey exit conference on 5/28/24. *The facility constructed an approximately 4' high knee wall on the left-side of the exit discharge to the dayroom/dining room on floors 3 through 6, however the facility is still non-compliant with the K-252 Number of approved exits-corridors as per NFPA 101. 2012 edition. 19.2.5.4 NJAC 8:39-31.2(e)	K 252	requested for the appropriate designation of a "defined" corridor in the dayrooms located on floors 6,5,4 and 3. (a) The facility has re-engaged architectural firm NJ Exec Order 26.4b1 to address the deficiency, and they will provide analysis and design to provide a compliant and achievable corrective action. Additionally we have engaged a second experienced architectural firm, NJ Ex Order 26. , PLLC to confirm that the plan meets ALL required NFPA codes. The architect has also explained that the required time to clarify, designing and specifying requirements would take considerable amount of time (as defined below). Therefore, the facility requests a time limited waiver. The correction action necessary will be determined upon successful evaluation by the design professionals to specify that design plan will create exit pathway that does not pass through an intervening room Based on the recommendations of the design professionals, the facility may be required to submit plans for approval to DOH and local township. (b)Estimated completion date: 12/31/24 2) How residents, staff and visitors will be kept safe during the time frame;	

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K 252	Continued From page 8	K 252	Alternate life safety measures that go above and beyond minimum requirements The facility has implemented additional education and in-servicing on critical lifesaving strategies that focus on fire prevention.This includes: • additional fire drills with a defined evacuation plan, evacuation techniques, fire exists and assembly points. (facility was previously doing monthly and will now be doing bi-monthly) • We are inspecting life safety and enhanced equipment monthly. • We have added additional fire extinguishers on each floor. • The existing structure and/or walls are marked with a 4 foot knee wall on floors 3 -6 thereby creating “visual” barriers to help staff identify the area that needs to always remain clear 3) Updates of Milestone dates of progress to DOH (survey program not licensing) • Contract with a new second architectural firm to provide a second opinion and with existing architectural firm to remediate and reach a proper conclusion with existing architectural firm. Completion of architectural review	

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K 252	Continued From page 9	K 252	and plans September 1, 2024 • Submission of plans and a project narrative to the New Jersey Department of Health for Functional Review and approval (if required) October 1, 2024 • Submission of plans to the Department of Community Affairs following DOH approval and receive approval (if required) November 1, 2024 • Secure general contractor and obtain local building permits (if required) December 1, 2024 • Contractor to begin work and completion December 20, 2024 • Certificate of Occupancy and DOH inspection December 31, 2024 4) Who will monitor progress, safety, etc and how often The Maintenance supervisor/Designee will continue to monitor life safety in the facility in accordance with regulations via monthly rounds on the audit tool, with focus on ensuring that the exit areas in the horizontal exit paths on Floors 3 through 6 are always clear of any obstacles. Audits will be done monthly	

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K 252	Continued From page 10	K 252	5) QAPI involvement and how often it will meet Monitoring of Life Safety in the facility (including any changes to the structure or the building) via monthly rounds and completion of quarterly in-services will be reported to the QAPI Committee on a quarterly basis to ensure on-going compliance. Findings will be discussed in the quarterly Quality Assurance Meeting and will be incorporated in the Facility Quality Assurance Program Project completion date: 12/31/24	
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation on 5/28/2024 in the presence of the facility U.S. FOIA (b)(6)), it was determined the facility failed to ensure illumination of means of egress in accordance with NFPA 101:2012 Edition, Section 7.8. This	K 281	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?	7/15/24

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K 281	Continued From page 11 deficient practice had the potential to affect all residents in 1 of 8 wings and was evidenced by the following: An observation on 5/28/24 at 12:58 PM of the 2 B wing rear exit stairs, revealed a section of the exit enclosure from the stairway landing door to the exit discharge had no illumination. A main light and emergency light were present but not operational. The facility U.S. FOIA confirmed the finding at the time. The U.S. FOIA (b)(6) was made aware during the Life Safety Code exit conference. NJAC 8:39-31.2(e)	K 281	The Maintenance Staff installed a light fixture by the exit enclosure from stairway landing door to the exit discharge of the 2 B wing rear exit stairs No residents were directly affected by this deficient practice. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. The Maintenance Director conducted rounds to ensure that facility follows regulations governing illumination of means of Egress 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator/Designee in-service Maintenance staff to ensure that facility is in compliance with regulations governing illumination of means of egress. Auditing tool was developed to document monthly rounds by the Maintenance Director. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:	

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K 281	Continued From page 12	K 281	Administrator /Designee will conduct monthly rounds x 6 months to ensure that all means of egress are illuminated Any issues will be corrected immediately. immediately for corrective actions. Findings will be submitted to the Quality Assurance Committee on a monthly basis x 6 months. Quality Assuarnce Committee will determine the need for further action plans if necessary.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/24/24 in the presence of the U.S. FOIA (b)(6) U.S. FOIA (b) it was determined that the facility failed to provide emergency lighting of at least 1-1/2 hour duration in accordance with NFPA 101-2012 edition 7.9, and 101:19.2.9.1. This deficient practice had the potential to affect 148 residents residing in the facility and was evidenced for 1 of 1 main generator transfer switches in the facility as follows: At 12:51 PM, the surveyor and U.S. FOIA observed in the main electrical room, that the generator transfer switch was not provided with emergency lighting. The U.S. FOIA indicated during the observation, that no emergency lighting was provided around the main	K 291	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Battery packed emergency lighting with 1-1/2 hours duration will be installed in the main electrical room around where the generator transfer switch is located. No residents were directly affected by this deficient practice. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 291	Continued From page 13 generator transfer switch. The [U.S. FOM] was informed of the finding at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	affected by the deficient practice. The Maintenance Director conducted rounds to ensure that the facility had appropriate lighting when required around the electrical rooms and generator transfer switch. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator/Designee in-serviced Maintenance staff to ensure that the facility had emergency lighting of at least 1□12-hour duration is provided automatically in accordance with 7.9, 18.2 and 19.2 in the electrical room over the generator transfer switch. An auditing tool was developed to ensure proper lighting is functioning in the electrical room over the generator transfer switch. The Maintenance Director will audit Weekly to ensure in place and functioning. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The Administrator or Designee will conduct monthly rounds x 6 months to ensure that the facili lighting is properly operating in the electrical room over the generator transfer switch. Any issues will be reported to the Quality Assuance committee immediately for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 291	Continued From page 14	K 291	corrective actions. Findings will be submitted to the Quality Asssurance Committee monthly x 6 months. Quarterly the Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet)	K 321		7/15/24

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 321	Continued From page 15 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/24/24, in the presence of the U.S. FOIA (b)(6) [redacted], it was determined the facility failed to ensure that fire rated doors to hazardous areas were self closing and separated by smoke resistive partitions in accordance with NFPA 101 (2012 Edition) Section 8.4. This deficient practice was identified in 10 of 27 doors observed, had the potential to affect 148 residents at the facility, and was evidenced by the following: A tour of the facility basement with the [redacted] on 5/24/24 between 11:42 AM and 1:00 PM revealed the following conditions: 1. The first laundry room (larger than 100 sq. ft.) entrance door was tied open and had no hardware leaving a hole in the door where the door handle belongs. There was white and orange foam sealant filling a 2 inch high opening above the door, that ran the length of the top door jamb. The [redacted] did not have documentation stating the sealant product's smoke resistance rating. 2. The second laundry room entrance door was blocked from closing by the strike plate sticking out. 3. The boiler room entrance fire door, when opened, stuck on the floor and would not close on its own. 4. The medical records room door did not latch.	K 321	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Maintenance staff addressed the following: The first laundry room door handle was replaced, and orange foam will be replaced with fire a sealant product smoke resistance rating The second laundry room entrance door strike plate was repaired The boiler entrance fire door was adjusted and closes freely The medical records room strike plate was adjusted shutting securely The smoke door by the stairs was adjusted to closed into the frame The backstair door was adjusted to close and latch The kitchen dry storage door closer was adjusted and closes freely The middle kitchen door adjusted to closed properly when magnetize The woman□s locker room door was adjusted to close and latch The stairwell #1 door was adjusted to close and latch 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 321	Continued From page 16 5. The corridor smoke door by stairs did not close into the frame. 6. The back stairwell door did not close into the frame and latch. 7. The kitchen dry storage room door was not provided with a self-closing device. 8. The middle kitchen door is held open by an electro-magnetic hold-open device. When released the door stuck to the floor and did not close. 9. The woman's locker room door did not close and latch. 10. The stairwell 1 door did not shut and latch on its own when opened and released. The U.S. FOIA (b)(6) was informed of the findings at the exit conference on 5/28/24. N.J.A.C. 8:39-31.2(e)	K 321	All residents have the potential to be affected by the deficient practice. The Maintenance Director conducted rounds to ensure that self-closing devices and hardware are installed on doors to hazardous areas. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator/Designee in-service Maintenance staff to ensure that self-closing devices and hardware are installed on all doors to hazardous areas. Maintenance will audit tool to ensure that self-closing devices and hardware are in operating monthly. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator/Designee will conduct monthly rounds x 6 months to ensure that self-closing devices and hardware are installed on all doors to hazardous areas. Findings will be submitted to the Quality Assurance Committee monthly basis x 6 months. Quarterly Quality Assurance committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101	K 324		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING 01 B. WING _____	05/31/2024

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K 324	Continued From page 17 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review on 5/23/24, in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure facility vendor report deficiencies were repaired as per NFPA 96, 19.3.2.5.3*(10) . This deficient practice had the potential to affect all residents residing in the facility and was evidenced by the following: A review of the facility's range-hood fire	K 324	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The repairs to the Kitchen fire suppression system were conducted by the fire suppression company and completed on 4/24 Fire Suppression system company sent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 324	Continued From page 18 suppression system report, dated 03/15/24 revealed the kitchen system report dated 3/15/24. The semi-annual report indicated the system is "Non-Compliant". The report under Description of Deficiencies stated that the: 1)- Pneumatic tubing is due for replacement. 2)- Incorrect position of nozzles protecting griddle.(need to relocate above perimeter) 3)-1 incorrect nozzle protecting range. In an interview, at the time, the [U.S. FOIA] acknowledged that the facility vendor report dated 3/15/24 did indicate that the kitchen system is Non-Compliant. The [U.S. FOIA] did not provide any further documentation indicating it was repaired. The [NJ Exec C] was notified of the finding at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e)	K 324	over documentation of said repairs 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Director of Maintenance will ensure that the facility Fire suppression systems were inspected and documented properly. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator educated the Maintenance Staff regarding the following: (a)Ensure kitchen fire suppression system gets inspected semi-annually and documented and if any repairs are needed, said repairs shall be completed in a timely fashion. (b) The Maintenance Director will maintain a log of Fire Suppression inspections with repairs made. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Maintenance Director/Designee will conduct semi-annual audits to ensure that (a) Kitchen fire suppression systems are inspected properly and in a timely fashion, and	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET** **DOVER, NJ 07801**

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K 324	Continued From page 19	K 324	(b) Have our licensed Kitchen fire suppression company repair any repairs promptly and well documented. Completed Audits Logs will be submitted to the Administrator on a semi-annual basis. Quarterly Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/28/24 in the presence of the facility's U.S. FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that the fixed interior wall surfaces have a flame spread rating of Class A or B in accordance with NFPA 101:2012, 10.2.3* and 10.2.8.1. This deficient practice had the potential to affect 125 residents residing at the facility and was evidenced for 7 of 8 corridors by the following:	K 331	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Facility contacted the vendor that completed installation of the 36-inch carpet on the lower section of the walls in the exit corridors in each floor. Requested vendor to send over all documentation related to the results of the	6/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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EXCEL CARE AT DOVER	**65 NORTH SUSSEX STREET** **DOVER, NJ 07801**

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K 331	Continued From page 20 During a tour of the facility on 5/28/24, the surveyor observed in exit corridors, (green) carpet on the lower section of the walls. The carpet measured approximately 36 inches up from the floor. The [redacted] was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. The [redacted] did not produce any documentation on the flame spread rating of the carpet. The [redacted] was notified of the findings at the Life Safety Code exit conference on 5/28/24. There were no further documents provided. * this K-331 was previously cited on the 5/2/22 Recertification survey. N.J.A.C. 8:39-31.2(e)	K 331	flame spread and smoke development testing of the carpets used on the vertical surfaces that was conducted in 2022. Documentation from vendor verified the wall carpet specifications, treatment of the carpets with shield plus fire retardant and confirmed that the flame spread rating of fixed interior wall surfaces meet the regulatory requirements. No residents were affected by the situation. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Facility□s Maintenance Director will maintain pertinent documentation related to ensuring that the facility is in compliance with regulations related to the Flame Spread rating of fixed interior wall surfaces. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator or designee will have the facility vendor conduct an evaluation of the carpets on the lower sections of the walls in the exit corridors in each floor to ensure that the facility is in compliance with regulations related to the Flame Spread rating of fixed interior wall surfaces.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 331	Continued From page 21	K 331	Any recommendations and/or measures taken to ensure compliance will be properly documented by the vendor and adhered to by the facility. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator will review documentation/reports by the facility vendor and will continue to monitor life safety in the facility on a monthly basis. Findings will be submitted to the Quality Assuarnce Committee on a monthly basis x 6 months. Quarterly the Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 5/23/24 it was determined the facility failed to test and maintain the fire alarm system at the required	K 345	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	8/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 345	Continued From page 22 frequency, and follow the certified vendors comments in accordance with NFPA 70 and NFPA 72. This deficient practice had the potential to affect all 148 residents and was evidenced by: 1. A documentation review on 05/23/24 of the fire alarm system reports, revealed that there were no semi-annual tests performed on the sealed lead-acid batteries. In an interview, the U.S. FOIA (b)(6) stated he could not find documentation of the semiannual battery testing. 2. During the documentation review, the surveyor determined there was over 14 months between annual fire inspections. Current inspection was conducted on 3/29/24 and the previous inspection was 1/6/23. 3. During record review the surveyor noted the contracted certified inspection company listed 12 devices related to the facility elevators were not inspected. 4. The facility failed to act on the following comments identified and listed on the report by the contracted inspection company: a. Must perform sensitivity testing on all smoke detectors. b. Must perform elevator function with elevator vendor. c. Must replace (2) 12v/ah batteries for FACP. d. Must replace (4) 12v/7ah for 2 BPS Panel, locations are listed on inspection report. e. Must replace (58) total heat detectors that have been recalled by manufacturer.	K 345	practice? 1.Maintenance Director will schedule with vendor semi-annual test on the sealed lead-acid batteries and documentation will be kept in compliance binder 2.The facility had identified deficient practice and QAPI was initiated for annual fire inspections 3.The certified Fire alarm system vendor is scheduled for an inspection of the 12 devices related to the facility elevator 4.The certified Fire alarm system vendor is scheduled for an inspection to: a.Perform sensitivity testing on all smoke detectors b.Replace of (2) 12v/ah batteries for FACP c.Replace (4) 12v/7ah for BPS panel as per inspection report d.Replace 58 total heat detectors that have been recall by manufacture e.The elevator function will be conducted with certified Fire alarm system vendor in conjunction with the elevator company 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Maintenance Director will schedule with vendor semi-annual test on the sealed lead-acid batteries and documentation will be kept in compliance binder 3) What measures will be put into place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 345	Continued From page 23 The [redacted] was notified of the findings at the Life Safety Code exit conference on 5/28/2024. N.J.A.C. 8:39-31.2(e) NFPA 70, 72	K 345	or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator in-serviced the Maintenance Department to test and maintain the fire alarm system at the required frequency, and follow the certified vendors recommendation in accordance with NFPA 70 and NFPA 72 Maintenance Director will audit using an audit tool to maintain compliance with NFPA 70 and NFPA 72 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator/Designee will conduct monthly rounds x 6 months to ensure that compliance with NFPA 70 and NFPA 72 Findings will be submitted to the QAPI Committee on a monthly basis x 6 months. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are	K 353		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 24 maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/23/24, 5/24/24 and 5/28/24 in the presence of facility management it was determined the facility failed to inspect and maintain its fire sprinkler system, missing 3 of its 4 quarterly inspections in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8 and NFPA 25:2011 Edition. These deficient practices had the potential to affect all 148 residents and was evidenced by: 1. On 5/23/24 during record review, the surveyor identified there was no documentation of 3 of the 4 quarterly and 1 annual sprinkler system inspections for 2023. The most current annual report was conducted on 3/22/24 and the last report provided was for an annual inspection on 12/28/22. The facility did not provide any quarterly inspections or an annual inspection for 2023. In an interview on 5/24/24 at 10:37 AM the U.S. FOIA (b)(6) stated that he looked for the 2023 sprinkler documents and could not	K 353	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? 1.The facility had identified missing quarterly and monthly sprinkler system reports for 2023 and initiated a QAPI plan to offset deficient practice 2.The Maintenance Director immediately removed all zip ties from fire sprinkler in the maintenance shop 3.The Maintenance Director replaced the drop ceiling tiles of exposing pipes in the basement hot water heater room. 4.Maintenance Director inspected 2 of 2 sprinkler heads for individual class C sprinkler system in the basement transfer room 5.The 1-inch diameter hole to the roof bottom containing a hatch was filled with fireproof material by Maintenance Director on the 6th floor hot water heater /chute room. Floors two through five hot water	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 353	Continued From page 25 find any reports. In an interview on 5/24/24 at 10:59 AM the U.S. FOIA (b) (6) stated he does not know what happened to the quarterly sprinkler reports, the former U.S. FOIA left. 2. On 5/24/24 at 11:48 AM the surveyor observed in the presence of the U.S. FOIA (b wires attached to a fire sprinkler pipe with zip ties in the maintenance shop. 3. On 5/24/24 at 12:15 PM the surveyor observed in the presence of the U.S. FOIA (b 2 drop ceiling tiles cut back for pipes leaving an opening approximately 18 inches by 4 feet in the basement hot water heater room. The opening in the ceiling would delay activation of the sprinkler head in the event of a fire. 4. On 5/24/24 at 12:55 PM in the basement transfer switch room, the surveyor observed in the presence of the U.S. FOIA, 2 of 2 sprinkler heads for an individual class C sprinkler system tagged for annual inspection on 9/2023 that had not been inspected monthly since 2/1/24. The tag was missing 2 of 8 monthly inspections. The U.S. FOIA stated he had not inspected them for March and April. 5. On 5/28/24 at 11:48 AM on the sixth floor hot water heater/ chute room, the surveyor observed in the presence of the U.S. FOIA the drop ceiling stopped mid room with the sprinkler head contained by the edge of the drop ceiling. The other half of the ceiling was open to the roof bottom containing a hatch with a 1 inch diameter hole passing sun light through. The opening in the ceiling would delay activation of the sprinkler	K 353	heater/chute rooms with full ceiling, 4 of 4 rooms on these floors penetration spaces in the ceiling tiles were replaced to reduce penetration space around pipes above the hot water heaters 6.Maintenance Director replaced escutcheon cap on missing sprinkler between rom 205-207 and replaced escutcheon cap on missing sprinkler in the activities room by porch entrance 7.No residents were adversely affected by the deficient practice. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Director of Maintenance inspected the facility sprinkler system for penetration holes, spaces around pipes and missing escutcheon caps. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator in-serviced the Maintenance Department to ensure compliance with maintenance and testing automatic sprinkler and standpipe systems are inspected, tested and maintained according NFPA -25. Monthly Audit form was developed for inspection, maintenance and testing of	

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K 353	Continued From page 26 head in the event of a fire. The [U.S. FOIA] stated he was aware of the hole. Floors two through five had similar hot water heater/ chute rooms with full ceilings, 4 of the 4 rooms on these floors had penetration spaces in the ceiling tiles around the pipes above the hot water heaters. 6. On 5/28/24 at 12:50 PM the surveyor observed in the presence of the [U.S. FOIA], that the escutcheon cap was missing on the corridor ceiling sprinkler between rooms [NJ Exec D] and [NJ Exec D]. 7. On 5/28/24 at 12:52 PM the surveyor observed in the presence of the [U.S. FOIA], that an escutcheon cap was missing on a sprinkler in the activities room ceiling by the porch entrance. The [U.S. FOIA] was informed of the deficient practices at the exit conference on 5/28/24. NJAC. 8:39-31.2(e) NFPA 13, 25	K 353	sprinkler system Maintenance Director/Designee will conduct monthly rounds x 6 months to ensure that compliance with NFPA-25 requirements. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator/Designee will conduct monthly rounds x 6 months to ensure that compliance with NFPA-25 requirements. Findings will be submitted to the Quality Assurance Committee monthly x 6 months. Quartertly Qaulity Assurce ommittee will determine the need for further action plan(s) to ensure on-going compliance.	
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		7/15/24

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 511	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 5/24/24 in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure electrical wiring complies with NFPA 70, National Electrical Code. This deficient practice had the potential to affect 148 residents residing in the facility and was evidenced by the following: 1) At 12:27 PM, the surveyor and U.S. FOIA observed in the basement power spray closet, that an unprotected electrical wire was plugged into a duplex wall outlet, then installed into the closet wall board horizontally to the right-side of the enclosed elevator shaft. In an interview at the time, the U.S. FOIA stated that the exposed wire was not protected and was not sure what the wire was providing electrical power to in the elevator shaft. 2) At 12:34 PM, the surveyor and the U.S. FOIA observed in the facility kitchen, that a large diameter black wire from an electric warming appliance was installed into the drop ceiling tile. It was unknown where the wire was getting power from in the drop ceiling. In an interview, at the time, the U.S. FOIA stated he was not sure where the wire was going or why it was not installed with protection as per NFPA 70. 3) At 11:16 AM on 5/28/24 the surveyor and U.S. FOIA observed the electrical panel in the fith floor corridor had no lock on it. 4) At 11:38 on 5/28/24 the surveyor and U.S. FOIA observed the electrical panel in the fourth floor	K 511	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director Investigated where the power was going to in the elevator shaft, Basement power spray closet, Electric warming appliance in the kitchen, and correctly reinstalled them as per NFPA 70 guidelines. Maintenance director/designee installed locks on 5th floor electrical panel and fourth floor electrical panel. No residents have been adversely affected by the deficient practice. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Director of Maintenance verified that all wiring is wired according to NFPA 70 guidelines 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator educated the Maintenance Staff to ensure that Electric panels and wiring is inspected	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 511	Continued From page 28 corridor had no lock on it. The [redacted] was informed of the deficient practices at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e) NFPA 70	K 511	and documented weekly and monthly (a) Rewire the faulty wires to meet the requirements of the NFPA 70 guidelines and continuously inspect them (b) Inspect each electric panel to insure its locked weekly. (c) audits will be performed bi-weekly Maintenance Director / Designee will Inspect Electric panel box weekly The Maintenance Director will audit throughout facility for any exposed or faulty wiring weekly. Audit tool will be developed to track. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The administrator or designee will conduct monthly audits of the Wiring and inspection Logs x 6 months to ensure that Maintenance Director is in compliance with the Gas and electric requirements. Results of the audits will be reported in the quarterly Quality Assurance Committee Meetings. Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall	K 521		7/15/24

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	315355	A. BUILDING 01 B. WING _____	05/31/2024

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K 521	Continued From page 29 comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 5/28/24 in the presence of facility management, it was determined that the facility failed to ensure ventilation operated properly in 5 of 8 observed resident bathrooms. This deficient practice had the potential to affect 30 residents and was evidenced by: During a tour of the facility on 5/28/24 between 10:35 AM and 1:32 PM, the surveyor observed testing of resident bathroom exhaust vents by the US FOIA (b) (6) . The testing revealed the vents in the bathrooms of rooms NJ Exec Order 26.4b1 and corridor bathroom by the nurses station on second floor did not work. The US FOIA (b) was informed of the deficient practice at the Life Safety Code exit conference on 5/28/24. N.J.A.C. 8:39-31.2(e), 8:39-31.8(a).	K 521	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The exhaust fans on the roof have been replaced to ensure that the ventilation in the following resident room bathrooms are properly functioning: Floor #6 Resident rooms NJ Exec O (1 -bathroom) Floor #5 Resident rooms NJ Exec O (1 -bathroom) Floor #4 Resident rooms NJ Exec O (1 -bathroom) Floor #3 Resident rooms NJ Exec O (1 -bathroom) Floor #2 Corridor bathroom by nurses station No residents were adversely affected by the deficient practice. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents who have access to the bathrooms in Resident Rooms U.S. FOIA (b),	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 521	Continued From page 30	K 521	NJ Exec Order 26.4b1 and Corridor bathroom by the nurses station on the second floor have the potential to be affected by the deficient practice. All residents have the potential to be affected by the absence of proper ventilation and exhaust vents or other approved means to resist the transfer of smoke into areas of refuge. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Maintenance director will repair faulty vents and replace parts needed in rooms #NJ Exec Order 26.4b1 and Corridor bathroom by the nurses station on the second floor. Maintenance Director will inspect and test all exhaust vents in the building monthly. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator/Designee will audit 5 resident bathrooms monthly to include inspection and testing of the ventilation systems to ensure proper air ventilation in resident bathrooms. Results of the audits will be documented in the Facility's Ventilation Testing Log. Findings will be submitted to the Quality Assurance committee monthly for 6 months. Quarterly the Quality Assurance	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 521	Continued From page 31	K 521	Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: During record review on 5/24/24, in the presence of the U.S. FOIA (b)(6) [redacted]), a) it was determined that the facility failed to test and inspect the elevator's annually with the New Jersey Department of Community Affairs Division of Codes and Standards Elevator Safety Division and/or AHJ. b) It was determined that the facility failed to ensure the phase-1 and phase-II monthly recall testing was properly documented. c) it was determined that the facility failed to maintain	K 531	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? a. The elevator company has completed annual inspections for 2023 and made all necessary repairs. The elevator company continued contacting NJ Exec Off [redacted] for a reinspection date.	7/15/24

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 531	Continued From page 32 elevator emergency communication for 2 of 2 passenger elevator telephones tested, in accordance with ASME/ANSI A17.3. This deficient practice had the potential to affect 80 residents who resided at the facility and was evidenced by the following: a). At 10:45 AM, a review of the facility's elevator inspection certificate's, revealed that 2 of 2 elevator devices #1 and #2 were last inspected and were certified for use until 8/14/23, and was over 8-months overdue. In an interview at 11:00 AM, the facility's [U.S. FOIA] stated he would communicate with [NJ Exec Off] to schedule an inspection as soon as possible. The observation of the signed off elevator certificate's in the elevator room confirmed 2 of 2 elevators were due for inspection. No further documentation was provided. b). At 11:02 AM the surveyor and [redacted] reviewed the Phase I and Phase II firefighters monthly recall documentation. The monthly results of operation indicated OK only and did not include evidence that Fire Fighters' Emergency Operations Inspection and Testing was performed and written record of Phase I recall by use of the key switch, and a minimum of one, floor operation, including findings documented monthly. In an interview at the time, the [U.S. FOIA] stated he was unaware of this requirement and would inform the vendor of what is required on the inspection documentation. c). At 11:49 AM, the [U.S. FOIA] conducted a test of the	K 531	b. The elevator company provided a more detail report regarding monthly firefighter□s phase I and phase II testing with evidence that the emergency operations inspection and testing performed that included the Phase I recall by use of key switch C. The elevator vendor was contacted to schedule and conduct a test of the emergency communication telephone system in the 2 facility passenger elevators for 6/26/24. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. The Director of Maintenance will ensure that the facility elevators are inspected annually and monthly on Phase I and Phase II as required. All documentation will be kept in our compliance book. 3)What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator educated the Maintenance Staff regarding the following: (a) Ensure that elevators are inspected yearly and on the Phase I and Phase II required monthly testing for elevators with detail description of such testing (b) Maintain an elevator emergency	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 531	Continued From page 33 emergency communication telephone system in the (2) facility passenger elevators. The emergency telephones did not function when the button was activated. In an interview at the time, the [NJ Exec] stated there was a communication issue between the telephone vendor and the elevator company. The [U.S. FOIA] was informed of the deficient practices at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. ASME/ANSI A17.3	K 531	communication line alarm for each elevator. (c A monthly tracking tool will be implemented Maintenance Director/Designee will conduct monthly audits to ensure that Elevators are inspected on the Phase I and Phase II required monthly testing for elevators, and. Elevator emergency communication is operable for each elevator. 4)How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator or designee will audit inspection log monthly to ensure inspections are being conducted. Completed Audits Logs will be submitted to the QAPI committee monthly x 6 months. Quarterly Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		7/15/24

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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K 918	Continued From page 34 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 5/23/24, in the presence of the U.S. FOIA (b)(6)), it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was evidenced for 1 of 1 generators and had the potential to affect 148 residents residing	K 918	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Director conducted the Generator Testing to ensure that the time needed by their generator to transfer power to the building was within the required 10-second time frame.	

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	315355	A. BUILDING 01 B. WING _____	05/31/2024

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K 918	Continued From page 35 in the facility and was evidenced by the following: At 9:44 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds for 12 of 12 times on the provided generator log. Currently, the [redacted] was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 5/26/23, 6/23/23, 7/21/23, 8/11/23, 9/29/24, 10/20/23, 11/24/23, 12/29/23, 1/19/24, 2/23/24, 3/28/24, and 4/30/24. An interview was conducted with the [redacted] during document review, where he stated that currently he was not putting the transfer time on the provided generator monthly load test log. The [redacted] was informed of the deficient practice at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Residents were not adversely affected by the deficient practice 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents have the potential to be affected by the deficient practice. Director of Maintenance/Designee will ensure that Generator Testing is performed and logged as scheduled: o Exercise the Emergency Generator Weekly o Monthly Full-Load Generator testing 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Administrator educated the Maintenance Staff to ensure that Generator Testing is performed and the Weekly and Monthly Logs are completed promptly and properly, including but not limited to the following: (a) Certify the time needed by the generator to transfer power to the building is within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and (b) Exercise the emergency electrical generator on load for 12 times each year Administrator / Designee will review the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 918	Continued From page 36	K 918	Generator testing logs weekly to ensure testing is being completed as required. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator or designee will conduct monthly audits of the Generator Logs for 6 months to ensure that Maintenance Director is compliant with the Generator Testing requirements. Results of the audits will be reported in the quarterly Quality Assurance Committee Meetings. Quality Assurance Committee will determine the need for further action plan(s) to ensure on-going compliance.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. BUILDING 01 B. WING _____	05/31/2024

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K 923	Continued From page 37 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 5/23/24, in the presence of the U.S. FOIA (b)(6) US FOIA (b)(6) it was determined that the facility failed to prohibit combustible storage within 5-feet of quantities of oxygen exceeding 300 cubic feet in accordance with NFPA 99. This deficient practice was identified for 55 of 55 portable oxygen cylinders, had the potential to affect 25 residents residing at the facility, and was evidenced by the following: At 1:15 PM, the surveyor and U.S. FOIA observed in the floor #1 main oxygen storage closet, that 55 portable oxygen cylinders were stored within 5' of combustible cardboard boxes , plastic bags and bins exceeding 300 cu. ft. to 3000 cu. ft. as per NFPA 99 2012 11.3.2.1 through 11.3.2.3	K 923	1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? The Maintenance Staff removed the cardboard boxes, plastic bags, and any other combustible material□s. All oxygen cylinders have been separated with at least 5 feet of space from combustible storage. 2) How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	

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	315355	A. BUILDING **01** B. WING _____	**05/31/2024**

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

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K 923	Continued From page 38 In an interview at the time, the [redacted] stated the cylinders must be separated by five-feet (5') from combustibles and identified with signs indicating full and empty cylinders. The[redacted] was informed of the deficient practices at the Life Safety Code exit conference on 5/28/24. NJAC 8:39-31.2(e) NFPA 99	K 923	All residents have the potential to be affected by the deficient practice. Director of Maintenance conducted rounds to ensure that all oxygen cylinders are stored in areas at least 5 feet of space from combustible storage. 3) What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? Facility staff was in-serviced regarding ensuring that all oxygen cylinders are stored in areas at least 5 feet of space from combustible storage. Maintenance Director or designee will conduct rounds twice a week that all oxygen cylinders are stored in areas at least 5 feet of space from combustible storage. Any concerns will be addressed. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: Administrator/Designee will conduct monthly rounds to ensure that all oxygen cylinders are stored in areas at least 5 feet of space from combustible storage. Any concerns will be addressed. Findings will be submitted to the safety committee monthly. Findings of audits will be reported in the Quarterly QAPI Meeting. QAPI Committee will determine the need for further action plan(s) to ensure on-going compliance.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315355 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT DOVER	65 NORTH SUSSEX STREET DOVER, NJ 07801

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	07/15/2024	LSC K0211	06/14/2024	LSC K0252	08/16/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	07/15/2024	LSC K0291	07/15/2024	LSC K0321	07/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	07/15/2024	LSC K0331	06/14/2024	LSC K0345	08/16/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	07/15/2024	LSC K0511	07/15/2024	LSC K0521	07/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	07/15/2024	LSC K0918	07/15/2024	LSC K0923	07/15/2024

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

FOLLOWUP TO SURVEY COMPLETED ON	
5/31/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO