| 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 08/02/2022 |

| 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 000 | INITIAL COMMENTS<br><br>Survey date: 08/02/2022<br><br>Census: 125<br><br>Sample: 5 residents/5 staff<br><br>A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. | F 000 | | |

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

Electronically Signed | 08/15/2022

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.

| 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 08/02/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Survey date: 8/02/2022<br><br>Census: 125<br><br>Sample size: 5 residents/5 staff<br><br>A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities, infection control regulations and has implemented Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. | S 000 | | |
| S 560 | 8:39-5.1(a) Mandatory Access to Care<br><br>(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and review of 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. This was evident for 6 out of 14 shifts reviewed.<br><br>Findings include:<br><br>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) | S 560 | I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:<br><br>The facility actively seeks to hire CNAs; ensure that all shifts are scheduled to comply with State-mandated ratios, and make sure that any callouts or no-shows result in calls being made by the Staffing Coordinator or Nursing supervisor to fill the shift. | 8/25/22 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 08/15/22 |

| 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 1<br>30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 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:<br><br>One Certified Nurse Aide (CNA) to every eight residents for the day shift.<br><br>One direct care staff member to every 10 residents for the evening shift, provided that no fewer 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<br><br>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.<br><br>During entrance conference on 8/2/22 at 8:45 AM, the Director of Nursing (DON), informed the surveyor that the facility staff varied depending on the time. The DON stated that the facility used contracted Agency staff to help with shortages as well as hiring new staff.<br><br>As per the "Nurse Staffing Report" completed by the facility for the weeks of 7/17/22 to 7/23/22 and 7/24/22 to 7/30/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below:<br><br>07/19/22 had 14 CNAs for 124 residents on the day shift, required 15 CNAs.<br>07/24/22 had 13 CNAs for 126 residents on the | S 560 | Recruitment efforts by the facility to hire CNAs, include the following: Aggressively running ads through various social media platforms; Utilization of employment application websites; and fostering partnerships with recruitment and employment agencies.<br>No residents have been adversely affected by the deficient practice.<br><br>II.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE<br>All residents have the potential to be affected by this deficient practice.<br><br>III.SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR<br>Facility□s Recruitment and Retention Strategies and Efforts have been in progress, which include but are not limited to the following:<br>o Aggressively run ads in various social media platforms and employment application websites<br>o Contract with staffing agencies<br>o Offer Sign on bonuses to attract staff<br>o Recruitment bonus to encourage referrals from current staff<br>o Offer daily and weekend bonuses (gift cards) to attract overtime or PRN staff shifts<br>o Regularly meet with Staff to boost morale<br>o Conduct Staff Appreciation programs and activities to promote Staff Retention | |

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|---|---|---|---|---|
| S 560 | Continued From page 2<br>day shift, required 16 CNAs.<br>07/25/22 had 13 CNAs for 126 residents on the day shift, required 16 CNAs.<br>07/26/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs.<br>07/27/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs.<br>07/30/22 had 15 CNAs for 125 residents on the day shift, required 16 CNAs.<br><br>NJAC 8:39-5.1(a) | S 560 | IV.MONITORING OF CORRECTIVE ACTIONS<br>¿Director of Nursing or designee will submit monthly reports to the QAPI (Quality Assurance and Performance Improvement) Committee X 6 months, regarding all efforts made to try to comply with the State□s Staffing Ratios. Reports will include the status of all recruitment and retention efforts. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further action plans. | |

# STATE FORM: REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 061423 Y1 | A. Building<br>B. Wing Y2 | 9/26/2022 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EXCEL CARE AT DOVER | 65 NORTH SUSSEX STREET<br>DOVER, NJ 07801 |

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # 8:39-5.1(a) | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | 08/25/2022 | 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 |
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| 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 | |
|---|---|
| 8/2/2022 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |