

New Jersey State Department of Health

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>01001</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>10/16/2025</b>
NAME OF PROVIDER OR SUPPLIER <b>EXCEL CARE AT EGG HARBOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6818 DELILAH ROAD , EGG HARBOR TOWNSHIP, New Jersey, 08234</b>	
(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
S0000	Initial Comments  Complaint: 2636420Survey date: 10/16/25Census: 112Sample: 5A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

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