STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234**

(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 Standard Survey: 01/27/2025 to 01/31/2025 Census: 118 Sample Size: 32 + 2 closed records C/O #'S NJ 172248, 177085, 177719,180562, 182995 A Recertification/LSC survey was conducted from 01/27/2025 through 01/31/2025, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the survey, a finding which constituted Immediate Jeopardy (IJ) was identified under 42 CFR 483.25(d)(2) F 689 as the facility failed to ensure a NJ Ex Order 26.4(b)(1) resident with a known history of NJ Ex Order 26.4(b)(1) the facility on NJ Ex Order 26.4(b)(1). Resident #160, who NJ Ex Order 26.4(b)(1) that the physician ordered to be checked every shift for placement and function was last checked on NJ Ex Order 26.4(b)(1) at 02:00 PM, and was NJ Ex Order 26.4(b)(1) by staff on NJ Ex Order 26.4(b)(1) between 05:00 PM and 05:30 PM. The Registered Nurse (RN #1) documented that the resident was NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) at 07:40 PM, to receive their medications. On NJ Ex Order 26.4(b)(1) between 08:00 PM and 09:00 PM, the Certified Nursing Assistant (CNA #3) noted that the resident was NJ Ex Order 26.4(b)(1) and did not touch their dinner. On 12/12/2024 at 09:30 PM, CNA #3 could NJ Ex Order 26.4(b)(1) the resident, informed RN #1, and NJ Ex Order 26.4(b) the resident. NJ Ex Order 26.4(b)(1) were notified and began their own NJ Ex Order 26.4 on NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4 the resident in the facility's NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1) at 01:45 AM. The resident was assessed and immediately sent to the hospital where the	F 000		

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

Electronically Signed | 02/23/2025

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 000	Continued From page 1 resident was admitted for NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted] . The facility's failure to provide adequate supervision to a NJ Ex Order 26.4(b)(1) resident who was at risk for NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 posed a likelihood of serious harm, injury, impairment or death. This resulted in an Immediate Jeopardy (IJ) situation which ran from NJ Ex Order 26.4(b)(1) at 05:30 PM, when Resident #160 was last seen by staff, until NJ Ex Order 26.4(b)(1) at 01:45 AM, when the NJ Ex Order 26 [redacted] the resident and sent them to the hospital. The IJ was Past Non-Compliance (PNC). The PNC IJ was identified from NJ Ex Order 26.4(b)(1) at 05:30 PM, which continued to NJ Ex Order 26.4(b)(1) at 01:45 AM, when the resident was NJ Ex Order 26 and sent to the hospital for evaluation. The facility was back in compliance when the facility addressed the situation by immediately NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) the resident; the resident was sent to the hospital for evaluation; the NJ Ex Order 26.4(b)(1) system was checked for function; all NJ Ex Order 26.4(b)(1) were checked; and all staff were inserviced on the facility's NJ Ex Order 26.4(b)(1) protocol. A Partial Extended Survey was initiated after the deficiency was identified at the IJ/SQC (substandard quality care) level. The U.S. FOIA (b) (6) [redacted] was informed of the F 689 PNC IJ and was provided with the IJ template on 01/30/2025 at 04:31 PM. The acceptable Removal Plan on 01/31/2025 at	F 000		

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F 000	Continued From page 2 01:16 PM, indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: staff initiated the elopement protocol and contacted the police; Resident #160 was located outside the facility, assessed, and transported to the hospital for evaluation; Resident #160's plan of care was updated to include 1:1 supervision; Resident #160's wander guard was checked for function; the facility's wander guard system was checked for function; and all staff were educated on the facility's elopement protocol. The facility self-corrected the deficient practice and it was determined that IJ was PNC; that the facility corrected their non-compliance on 12/30/2024. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 01/31/2025.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		3/17/25

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F 550	Continued From page 3 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the residents' leisure experience was provided in a manner to promote the dignity and respect of the residents, a) who were seated in the dayroom where a television program broadcast contained profanity and vulgar language was observed for 1 of 2 dining rooms, first floor, b.) the facility failed to maintain Resident dignity when staff were observed standing while [redacted] Residents their meals on 3 of 3 dining rooms observed for dining and c.) did not serve all residents seated at the same table at the same time for 1 of 3 dining	F 550	Based on observation and interview, it was determined that the facility failed to ensure that the residents' leisure experience was provided in a manner to promote the dignity and respect of the residents, a) who were seated in the dayroom where a television program broadcast contained profanity and vulgar language was observed for 1 of 2 dining rooms, first floor, b.) the facility failed to maintain Resident dignity when staff were observed standing while [redacted] Residents their meals on 3 of 3 dining	

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F 550	Continued From page 4 areas, 2nd floor. This deficient practice was evidenced by the following: During the initial tour of the facility on 01/27/2025 at 7:15 PM, Surveyor #1 entered the first-floor dayroom. There were four residents and one staff member in the room. For entertainment the staff had the television playing. The surveyor observed on the television was a comedian using curse words and [NJ Exec Order 26.4b1] repeatedly. At 7:19 PM, Surveyor #1 approached the [US FOIA (b)(6)] who was seated at the nurse's station. Together they returned to the first-floor dining room where the program was still playing. The [US FOIA (b)(6)] acknowledged the profanity and stated the activities staff usually put the television on in the dining room for the residents. The [US FOIA (b)(6)] stated the staff in the room should have changed the program to something more appropriate. At 7:24 PM, Surveyor #1 interviewed the Certified Nursing Assistant (CNA #1) who was present in the dining room. CNA #1 stated she had not heard the cursing or the slurs because she was concentrating on the residents she was seated with. CNA #1 further stated that language would be inappropriate, and the television station should have been changed. During an interview with Surveyor #1 on 01/29/2025 at 12:20 PM, the [US FOIA (b)(6)] stated the activities staff had a schedule for daily entertainment. Usually when there was no activity going on the staff would put the television on instead. The [US FOIA (b)] added that a CNA	F 550	rooms observed for dining and c.) did not serve all residents seated at the same table at the same time for 1 of 3 dining areas, 2nd floor. 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. TV channel was changed immediately. Education was completed by [US FOIA (b)(6)] on 2/13/25 for all facility staff to ensure television programs in communal areas are appropriate for the general audience. b. Education was completed by [US FOIA (b)(6)] on 2/13/25 for all nursing staff regarding proper protocols and manners when assisting residents with meals in the dining room. Nursing staff was reminded to seat in front of the resident when assisting with meals. i. Hospice provider was notified of deficient practice, and education was requested to be completed for all hospice aids (HA). ii. [US FOIA (b)(6)] was educated about seating while assisting residents with meals. iii. Education was provided to CNA #4, LPN #5 and all nursing staff to ensure hair is tied back to ensure it does not come in contact with residents meal trays. iv. Education was provided to CNA #5 and all nursing staff to ensure residents are fed in a timely manner to ensure optimal food temperature and covering food to ensure temperature is maintained. v. Education was provided to LPN #5 about seating while assisting residents with meals.	

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F 550	Continued From page 5 would remain in the room with the residents for safety and interaction. The television program should be something that can be viewed by a general audience. The [US FOIA (b)] confirmed the program the surveyor described with foul language and [NJ Exec Order 26.4b1] would not be appropriate and the channel should have been changed. On 01/28/2025 at 12:09 PM, in the first-floor main dining room, a surveyor observed CNA #1 and a Certified Home Health Aide for a [NJ Exec Order 26.4b] company, standing while each were feeding a resident at the same table, during the lunch meal. On 01/28/2025 at 12:09 PM, in the second-floor main dining room, surveyor #2 observed CNA #2 standing next to a resident assisting with feeding, during the lunch meal. On 01/28/2025 at 12:16 PM in the second-floor main dining room surveyor #2 observed the [US FOIA (b)(6)]) standing while [NJ Exec Order 26.] a resident. During an interview with surveyor #2 on 01/29/2025 the [US FOIA (b)] said the expectation when assisting residents with [NJ Exec Order 26.] is to sit facing the resident. The [US FOIA (b)] also said she should have pulled up a chair to [NJ Exec O] the resident instead of standing. During an interview with Surveyor #2 on 01/29/2025 at 04:12 PM, the [US FOIA (b)(6)] said that staff should be sitting at eye level with the resident when assisting with [NJ Exec Order 26.4b] for the dignity of the resident.	F 550	c. Education was completed by [US FOIA (b)] on 2/13/25 for all nursing staff to ensure all residents seating at the same table are served and assisted with meals at the same time. 2. 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. 3. Systemic changes to ensure that the deficient practice does not recur: a. The recreation department or designee will ensure that appropriate TV programs for the general audience are on TV in communal areas. b. The dining room workflow was revised by Quality Assurance Director (QAD) and clinical team for infection control practices and dining room etiquette. Education was provided to all nursing staff about the revised workflow for the dining room experience. The QAD or designee will oversee the dining room workflow daily to ensure compliance. c. Same as above. 4. Monitoring corrective actions: a. The Director of Activities or designee will audit TV programs in the communal areas weekly for 1 month and monthly for 5 months to ensure appropriate shows are on for the general audience. b. The dining workflow will be audited weekly for 1 month and then monthly for 5 months to ensure proper infection control, all residents are assisted with meals at the same time and staff are seated while assisting resident with meals. c. Results of the monitoring will be	

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F 550	Continued From page 6 On 01/28/2025 at 11:53 AM, Surveyor #3 observed seven residents who required assistance to consume their meals seated at the same table in the feeding dining room on the 2nd floor during lunch. Two facility staff members were stationed in the area to assist. Three residents received their meals and started eating, while the other four residents at the table did not receive their meals until 12:10 PM. On 01/28/2025 at 12:11 PM, Surveyor #3 observed Licensed Practical Nurse (LPN #5) in the feeding dining room on the 2nd floor during lunch, [redacted] a resident with their meal while standing over her/him. On 01/28/2025 at 12:15 PM, Surveyor #3 observed CNA #4 and LPN #5 [redacted] residents in the feeding dining room on the 2nd floor during lunch. Both staff members had their hair styled in braids, which touched several residents' food items multiple times as they brushed their hair away from their faces without performing hand hygiene. On 01/29/2025 at 12:04 PM, Surveyor #3 observed six residents who required assistance to consume their meals seated at the same table in the feeding dining room on the 2nd floor during lunch. Two facility staff members were stationed in the area to assist. Two residents received their meals and started eating, while the other four residents did not receive their lunch until 12:25 PM. On 01/29/2025 at 12:08 PM, Surveyor #3 observed CNA #5 in the feeding dining room on the 2nd floor during lunch. CNA #5 uncovered a	F 550	reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

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F 550	Continued From page 7	F 550		

resident's meal, set it up, removed the meal from the tray, and began [redacted] the resident at 12:08 PM. However, CNA #5 [redacted] the resident to put clothing protectors on other residents, leaving the resident's food uncovered for eight minutes. CNA #5 [redacted] the resident at 12:16 PM, but did not engage with the resident during the meal. She interrupted the [redacted] again to inform another staff member that she needed to go to the bathroom. CNA #5 then stood up, left the dining room, leaving the resident's food uncovered, and returned two minutes later to [redacted] the resident.

On 01/29/2025 at 12:28 PM, Surveyor #3 observed a resident sitting in a [redacted] in the corner of the feeding dining room on the 2nd floor during lunch, with a bedside table placed over it. CNA #5 uncovered the resident's meal, set it up and removed the food from the tray at 12:28 PM, but no one began [redacted] the resident until 12:42 PM.

During an interview with Surveyor #3 on 01/29/2025 at 12:26 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM #1), said that once residents' food is set up and uncovered, it should be fed to the residents immediately, as food should not be left uncovered due to infection control.

During an interview with Surveyor #3 on 01/29/2025 at 12:52 PM, the [redacted]) said that once residents' food is set up and uncovered, it should be served to them immediately, as leaving food uncovered poses infection control risks.

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F 550	Continued From page 8 During an interview with Surveyor #3 on 01/31/2025 at 11:45 AM, the [redacted] emphasized the importance of creating a home-like environment in the dining area. He said that meals should be served by removing them from trays, with all residents at a table being served simultaneously. He noted that staff members' hair should not come into contact with residents or their food while feeding, and that hand hygiene should be performed if staff touch their hair due to infection control concerns. Additionally, he highlighted the need for staff to actively engage with residents during mealtimes. He also mentioned that food should be covered to prevent infection and should not be left out for extended periods, as this could cause it to become cold. A review of a facility policy dated 05/01/2024, titled, "Dining Policy", revealed, "Resident Rights: Preferences, cultural needs, and dignity are respected." NJAC 8:39-4.1(a)(12)	F 550		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 582		3/17/25

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F 582	Continued From page 9 (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.	F 582		

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F 582	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for Beneficiary Protection Notification, (Resident #1 and Resident #27). This deficient practice was evidenced by the following: On 01/28/2025 at 01:25 PM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident #1 and Resident #27 as follows; 1.The SNFBPNR indicated Resident # 1 last covered [NJ Exec Order 26.4b1] day was [NJ Exec Order 26.4b1] and Resident # 1 remained in the facility. The SNFBPNR further revealed that a "Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055" was not given to Resident #1. Under 1. Was a SNFABN, Form CMS-10055 provided to the resident? No was checked. If no explain why the form was not provided: was hand written Resident remained in the facility is [NJ Exec Order 26.4b1] pending. 2. The SNFBPNR indicated Resident #27 last covered [NJ Exec Order 26.4b1] day was [NJ Exec Order 26.4b1] and Resident #27 remained in the facility. The SNFBPNR further revealed that a "Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage Form CMS-10055" was not given to Resident #27. Under 1. Was a SNFABN, Form CMS-10055 provided to the resident? No was checked. If no explain why the form was not provided: was hand written Resident remained in the facility.	F 582	Based on interview and review of other facility documentation, it was determined that the facility failed to issue the required beneficiary notices for 2 of 3 residents reviewed for Beneficiary Protection Notification, (Resident #1 and Resident #27). 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. Resident #1 was informed facility failed to issue the required beneficiary notice. Proper beneficiary notice was provided. b. Resident #27 was informed facility failed to issue the required beneficiary notice. Proper beneficiary notice was provided. c. Education was completed by [US FOIA (b)(6)] to ensure residents receive proper beneficiary notices on 02/04/2025. 2. 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. 3. Systemic changes to ensure that the deficient practice does not recur: a. The Administrator and Social worker will review all SNFABN and NOMNC notices during daily morning meeting to ensure residents receive appropriate beneficiary notices. 4. Monitoring of corrective actions: a. The Administrator or designee will audit all beneficiary notices completed	

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 582	Continued From page 11 During an interview with the surveyor on 01/29/2025 at 10:32 AM, the[US FOIA (b)(6)]) was asked what SNFBPN were provided to a resident who is discharged home. The [US FOIA] replied We give them[NJ Ex Order 26.4(b)(1)] NOMNC (Notice of Medicare non-coverage CMS-10123). We provide copies of the forms to the resident. The surveyor then questioned what forms are required to be provided to a resident who the facility initiated discharge from [NJ Exec Order 26.4b1] services and remained in the facility. The SW replied we give them the SNFABN and NOMNC form because they are staying in house. We issue them 2 days before the last covered day to give them an opportunity to appeal. On 01/29/2025 at 10:46 AM, the [US FOIA] confirmed the 2 resident who stayed in facility after being cut from [NJ Exec Order 26.4b1] should have received SNFABN and NOMNC.	F 582	weekly for 3 months and then monthly for 3 months to ensure beneficiary notices are completed correctly. b. Results of the monitoring will be reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	
F 584 SS=E	NJAC 8:39-4.1(a)(7) 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.	F 584		3/17/25

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F 584	Continued From page 12 (i) This includes ensuring that the resident can receive care and services safely and that the 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: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a "homelike environment" by serving meals on trays on 1 of 2 floors (2nd floor). This deficient practice was evidenced by the following:	F 584	Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a "homelike environment" by serving meals on trays on 1 of 2 floors (2nd floor). 1. Corrective Actions Accomplished for residents found to have been affected by	

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F 584	Continued From page 13 On 01/28/2025 at 11:53 AM, Surveyor #1 observed Certified Nursing Assistant (CNA #4) in the feeding dining room on the 2nd floor during lunch, [NJ Exec Order 26] a resident their meal without removing the food items from the meal tray. On 01/28/2025 at 11:54 AM, Surveyor #1 observed a facility staff member in the feeding dining room on the 2nd floor during lunch bringing in a meal tray for a resident and began [NJ Exec Order 26] the resident without removing the food items from the tray. The [US FOIA (b)(6)]) entered the dining room and intervened, instructing the staff member to remove the food items from the tray while feeding the resident. On 01/29/2025 at 12:26 PM, Surveyor #2 observed CNA #5 in the feeding dining room on the 2nd floor during lunch, uncovering a resident's meal, setting it up, and serving it on the meal tray without inquiring about the resident's preferences. During an interview with Surveyor #1 on 01/31/2025 at 11:45 AM, the [US FOIA (b)(6)]) emphasized the importance of creating a home-like environment in the dining area. He said that meals should be served by removing them from trays. A review of a facility policy dated 05/01/2024, titled, "Dining Policy", revealed, "Resident Rights: Preferences, cultural needs, and dignity are respected. Dining Environment: Clean, comfortable, and promotes resident independence." NJAC 8:39-31.3(a)	F 584	the deficient practice: a. The QAD intervened and educated CNA #4 to remove all items from the serving tray before assisting with meals. Education was complete by the Unit Manager. b. CNA #4 and CNA #5 and all nursing staff educated by Unit Manager on ensuring residents are served in homelike environment by removing all items from the serving tray. 2. 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. Education was complete on all staff by 3/17/25. 3. Systemic changes to ensure that the deficient practice does not recur: a. The dining room workflow was revised by Quality Assurance Director (QAD) and clinical team for infection control practices and dining room etiquette. Education was provided to all nursing staff about the revised workflow for the dining room experience. The QAD or designee will oversee the dining room workflow daily to ensure compliance. 4. Monitoring of corrective actions: a. The dining workflow will be audited weekly for 1 month and then monthly for 5 months to ensure proper infection control, all residents are assisted with meals at the same time, staff are seated while assisting during meals, and ensure residents are served in a homelike environment by placing all items directly on the table from the tray.	

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F 584	Continued From page 14	F 584	b. Results of the monitoring will be reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		3/17/25

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F 609	Continued From page 15 Refer to F 689 C/O # NJ 182995 Based on interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to report and submit the facility investigation to the New Jersey Department of Health (NJDOH) within 5 days, specifically when a resident NJ Ex Order 26.4 for 1 of 3 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #160). This deficient practice was evidenced by the following: A review of the EMR on 01/30/2025 at 2:20 PM revealed the following: According to the Admission Record Resident #160 was admitted with diagnoses including but not limited to: NJ Exec Order 26.4b1. A review of the most recent comprehensive Minimum Data Set (MDS) an assessment tool dated NJ Exec Order 26.4b1 revealed Resident #160 had a Brief Interview for Mental Status (BIMS) score of NJ /14 indicating Resident #160 was NJ Exec Order 26.4b1 A further review of the MDS indicated the resident was NJ Exec Order 26.4b1 with no NJ Exec Order 26.4b1 and used a NJ Exec Order 26.4b1. A review of the Order Summary Report revealed a physician order dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b on NJ Exec Order 26.4b1 placement and function every shift. A review of the Medication Administration Record (MAR) dated NJ Exec Order 26.4b1 revealed the aforementioned physician order for the NJ Exec Order 26. . A further review of the MAR indicated that	F 609	Based on interview, review of the Electronic Medical Record (EMR) and review of other facility documentation, it was determined that the facility failed to report and submit the facility investigation to the New Jersey Department of Health (NJDOH) within 5 days, specifically when a resident NJ Ex Order 26.4 for 1 of 3 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #160). 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. AAS-45 was submitted to DOH on 1/30/2025. 2. Identification of residents who have the potential to be affected by the same deficient practice: All residents involved in reportable events have the potential to be affected by the deficient practice. 3. Systemic changes to ensure that the deficient practice does not recur: a. The Administrator, Director of Nursing or designee will ensure that all reportable events are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures.	

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F 609	Continued From page 16 the NJ Exec Order 26.4b1 for Resident #160 was signed as having been checked for NJ Ex Order 26.4(b)(1) and function on NJ Exec Order 26.4b1 at 6AM and 2 PM. A review of an NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 revealed a score of NJ and the following statements were checked; 2. Does Resident have a history of NJ Exec Order 26.4b1 or attempted leaving the facility without informing staff?, 4. Resident NJ Exec Order 26.4b1 6. Resident NJ Exec Order 26.4b NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1, 7. NJ Exec Order 26.4b likely to effect the NJ Exec Order 26.4b or NJ Exec Order 26.4b1 of self/others, and 8. the resident's NJ Exec Order 26.4b1 behavior likely to effect the privacy of others. It was noted that 10. The evaluation indicated that score of NJ or higher indicates risk of NJ Exec Order 26.4b1 was not checked. A review of Resident #160's care plan revealed a Focus area of Risk for NJ Exec Order 26.4b1 Under the Goal section; the resident will not leave the facility unattended. Under the Interventions section; Engaged Resident in purposeful activity with date initiated of NJ Exec Order 26.4b1, Provide Care in NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 with date initiated NJ Exec Order 26.4b1 Provide clear simple instructions with date initiated NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 as ordered to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 placement and function as ordered with date initiated NJ Exec Order 26.4b1. A review of the facility Investigation and Summary and Conclusion dated NJ Exec Order 26.4b1 revealed the following: Under the background section Resident has a history of NJ Exec Order 26.4b1 and NJ Exec O for which interventions have been put into place. Resident wears a NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. Under the timeline of Events NJ Exec Order 26.4b1 included	F 609	b. The Administrator, Director of Nursing or designee will communicate all reportable events to the Corporate Clinical team to ensure all reportable events are submitted to DOH in a timely manner. 4. Monitoring of corrective actions: a. The Administrator or designee will maintain a log of all reportable events with the time that event was reported to DOH to ensure compliance. b. The administrator or designee will audit the reportable event log weekly for 6 months to ensure all reportable events are reported within established time frames as per DOH regulations. c. Audit findings will be reviewed during the QAPI meetings quarterly for 6 months and corrective actions will be implemented as needed.	

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F 609	Continued From page 17 but not limited to: .[redacted]	F 609		

Approx 2:00 am Department of Health called to report on event.

During an interview on 01/30/2025 at 01:17 PM, the [redacted] said Yes, we notified the DOH.
On 01/30/2025 at 02:03 PM, the surveyor spoke with a Supervisor of Inspections at NJDOH, who said there was evidence of the facility calling DOH hotline but only left name, facility name and phone number.

On 01/30/2025 at 04:31 PM, [redacted] provided a copy of sent email for reporting purposes, but it was to the [redacted] not NJDOH. The [redacted] said he will search in sent emails for the notification to the NJDOH.

During a follow up interview with the surveyor on 01/31/2025 at 11:29 AM, the [redacted] were again asked was this reported as you said email was sent. The [redacted] said we can't find the email that the AAS 45 was sent to DOH, but I have a record of the call and we did not receive callback from DOH. When asked why you had not called again, and the [redacted] replied, at that time I did not think to call again.

During a post survey telephone interview on 02/03/25 10:19 AM the [redacted] was asked who is responsible to submit the AAS 45 and facility investigation to the department of health. The [redacted] replied "It's between me and the [redacted]" When asked is there a timeframe for when this is to be completed and submitted to the NJDOH, the [redacted] replied when the investigation is done, within 72 hours. We call it in then we

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F 609	Continued From page 18 usually wait for the DOH to call us back and tell us what else we need. A review of a facility policy titled Reporting Accidents and Incidents dated 05/01/2024 revealed under the Intent section: It is the policy of the facility to report Accidents and Incidents in accordance to State and Federal Regulations. Under the response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: ...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 ... NJAC 8:39-5.1(a)	F 609		
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: C/O # NJ 177719, 180562 Based on observation, interview, and review of the Electronic Medical Record (EMR), and review of other facility documentation, it was determined that the facility failed to a.) ensure medications were administered in accordance with a physician's orders, b.) failed to follow physician order specifically for obtaining a [redacted], and c.) ensure physician's medication order was transcribed accurately. This deficient practice	F 658	Based on observation, interview, and review of the Electronic Medical Record (EMR), and review of other facility documentation, it was determined that the facility failed to a.) ensure medications were administered in accordance with a physician's orders, b.) failed to follow physician order specifically for obtaining a urine culture, and c.) ensure physician's medication order was transcribed accurately. This deficient practice was	3/17/25

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 658	Continued From page 19 was identified for 3 of 32 sampled residents (Resident # 311, Resident #312, and Resident #414). 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 and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens 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 casefinding; 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.) Surveyor #1 reviewed the closed medical record on 01/29/2025 at 10:41 AM for Resident #312 as follows: A review of the Admission Record reflected the resident was admitted to the facility with diagnoses which included NJ Exec Order 26.4b1	F 658	identified for 3 of 32 sampled residents (Resident # 311, Resident #312, and Resident #414). 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. Education was completed by US FOIA (b) on 2/17/2025 to all qualified nursing staff regarding medication administration and ensuring medications are administered as per physician orders. An emphasis was made on pain medications. (a) Resident #312 was discharged from the facility. (b) Pharmacy was contacted to increase the variety of pain medications in the back up inventory. b. Education was completed by US FOIA (b) on 2/17/2025 to all qualified nursing staff regarding lab orders and collecting specimens as per physician orders. An emphasis was made on communicating to physician if specimen for lab orders were not collected. (a) Resident #311 was discharged from the facility. (b). Education was completed by US FOIA (b) on 2/17/2025 to all qualified nursing staff to ensure orders are transcribed accurately during the admission process and verifying all medication orders with physician prior to ordering medication from the pharmacy. (a) A medication error report was completed for resident #414. (b) Physician was notified of medication error and medication order was changed	

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F 658	Continued From page 20 NJ Exec Order 26.4b1 . A review of the most recent Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b, reflected a brief interview for mental status (BIMS) score of [redacted]/15, which indicated a [redacted] A further review reflected the resident had received NJ Exec Order 26.4b1 in the last seven days. A review of the individualized person-centered care plan reflected a focus area initiated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 in NJ Exec Order or NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1). Interventions included assess for NJ Exec Order [redacted] prior to beginning NJ Exec Order 26.4b1 program. Offer/administer PRN (as needed) NJ Exec Order 26.4b1 (NJ Exec Order 26.4b1 as ordered/indicated and monitor effectiveness. A review of the Order Recap Report (ORR) included the following a physician's orders (PO) NJ Exec Order 26.4b1 give 1 (one) tablet by mouth every 4 hours as needed for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 give 1 (one) tablet by mouth every 4 (four) hours as needed for NJ Exec Order 26.4b1 A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed the resident received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b at 9:42 PM, 11/24/24 at 12:01 AM, NJ Exec Order 26.4b1 at 7:30 AM and NJ Exec Order 26.4b at 7:40 AM documented as effective each time.	F 658	on 1/28/25. 2. 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. 3. Systemic changes to ensure that the deficient practice does not recur: a. The Director of Nursing or designee will review all residents admitted with pain medications to ensure medications listed are available in the back up inventory. If the medication is not available, it will be communicated to the physician. b. The Director of Nursing or designee will review all lab orders during morning clinical meeting to ensure specimens have been collected and ready for pick up. The Director of Nursing or designee will check specimen fridge at the end of 2-10 shift to ensure specimens were collected. If specimen was not collected, it would be communicated to physician. c. The evening shift supervisor will complete a second check on all new orders/admission orders to ensure medications were transcribed correctly from hospital/facility discharge summary. 4. Monitoring of corrective actions: a. The DON or designee will interview 5 residents with pain medication weekly for 4 weeks and then monthly for 5 months to ensure pain medication is administered and effective. (1) The DON or designee will audit 5 residents with pain medication orders weekly for 4 weeks and then monthly for 5 months to ensure medication is available in the back inventory.	

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F 658	Continued From page 21 A further review of the MAR revealed the resident received NJ Exec Order 26.4b1 on NJ Exec Order 26.4b at 12:41 PM documented as NJ Exec Order 26.4b1 A review of the facility automated medication dispensing machine Inventory on Hand report revealed the facility's machine stocked NJ Exec Order 26.4b1 tablets but did not stock NJ Exec Order 26.4b1 A review of the resident's Nursing Progress Notes for NJ Exec Order 26.4b1 did not reveal the US FOIA (b)(6) had contacted the physician for a change in medication for NJ Exec Order 26.4b1. On 01/28/2025 at 11:01 AM, the US FOIA (b)(6) provided a Resident/Family Concern Form dated NJ Exec Order 26.4b which revealed... resident #312 verbalized he/she wanted to NJ Exec Order 26.4b1 Resident #312 verbalized he/she was not satisfied because their medication was not given in a timely manner. During an interview with Surveyor #1 on 01/29/2025 at 11:34 AM, the US FOIA (b)(6) stated NJ Exec Order 26.4b1 was not stocked in the facility automated dispensing machine. Surveyor #1 then requested from the US FOIA (b) the signed pharmacy packing slip receipt for the resident's NJ Exec Order 26.4b1 which would indicate when the medication had arrived at the facility. On 1/30/25 at 9:40 AM the US FOIA (b) and the US FOIA (b)(6) requested to speak with the surveyor and in front	F 658	b. The DON will audit 10 lab orders weekly for 4 weeks and then monthly for 5 months to ensure lab order is entered, specimen collected, and results received and reviewed. c. The DON or designee will audit 5 admissions weekly for 4 weeks and then monthly for 5 months to ensure medication orders are transcribed correctly on admission. d. Audit findings will be reviewed during the QAPI meetings quarterly for 6 months and corrective actions will be implemented as needed.	

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F 658	Continued From page 22 of the survey team stated they had looked for the pharmacy packing slip and could not find a copy. [redacted] stated he then called the pharmacy to ask for a copy of the signed packing slip. After speaking with the pharmacy it seems the medication was not delivered to the facility, he believed it was because the resident had been [redacted] and the pharmacy required a written physical prescription before it would fill and deliver [redacted] medications. The [redacted] stated the nurse should have called the physician and made them aware the medication was not available and requested another medication for that [redacted]. A review of the facility's "Pain Management Program" policy dated 5/1/24, included... the facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental and psychosocial well-being... If the resident's pain is not controlled by the current treatment regimen, the practitioner should be notified... 2.) A review of Resident #311 EMR on 01/28/2025 at 10:17 AM revealed the following; According to the Admission Record, Resident #311 was admitted to the facility with diagnoses incluidng but not limited to: [redacted] A review of the most recent comprehensive MDS dated 9/26/24 revealed a BIMS score of [redacted]/15 indicating Resident #311 was [redacted]. The MDS further indicated the resident was [redacted] of [redacted] and [redacted]	F 658		

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F 658		F 658		

Continued From page 23

NJ Exec Order 26.4b1

A review of the OSR with active. completed and discontinued orders included a physician order dated NJ Exec Order 26.4b1 one time only related to NJ Exec Order 26.4b1.

A review of the Results tab in the EMR did not include results for the NJ Exec Order 26.4b1.

A review of the Progress notes dated NJ Exec Order 26.4b1 timed at 04:07 AM signed by the nurse ... NJ Exec Order picked up by lab tech during previous shift on NJ Exec Order 26.4b 2-10 shift.

A progress note dated NJ Exec Order 26.4b1 timed at 4:25 PM, signed by the provider, Member seen today for follow up NJ Exec Order 26.4b1 Provider US FOA contacted lab, NJ Exec Order 26.4b1) was not sent as ordered on NJ Exec Or.

During an interview with Surveyor #2 on 01/29/2025 at 11:44 AM, LPN #1 was asked what is the process when lab work is ordered by the physician. LPN #1 responded
I put the order in EMR under new then laboratory then it takes you to lab so we can directly order the lab. Surveyor #2 asked what is the process for when a NJ Exec Order 26.4b1 is ordered. LPN #1 said it is the same process when NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 We print the requisition and they also have the order on their app (application) on their phone. The requisition goes into the lab book. The nurse will collect the NJ Exec Or in AM. On the routine results if there was a problem it would be documented on the sheet for a NJ Exec Order 26.4b1 to be sent.

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F 658	Continued From page 24 On 01/31/2025 at 08:45 AM, Surveyor #2 requested [redacted] from the [redacted] On 01/31/2025 at 11:35 AM, the [redacted] told Surveyor #2 I can't find results. During an interview with Surveyor #2 on 01/31/2025 at 12:14 PM, the [redacted] was asked what is the process when lab work is ordered by the physician. The [redacted] replied put the order in EMR and goes directly via computer to the lab. The [redacted] was questioned what is the process for when a [redacted] is ordered. The [redacted] replied the same thing and if lost need to get another order and obtain the [redacted] The [redacted] followed up in her note and spoke with the nurse who said the [redacted] was not sent on day it was ordered. The [redacted] confirmed the [redacted] should have been sent on day it was ordered. The facility was unable to provide a policy regarding [redacted]. 3.) A review of Resident #414's EMR on 01/28/2025, revealed the following: According to the Admission Record, Resident #414 was admitted to the facility with diagnoses including but not limited to: [redacted] A review of the most recent MDS dated [redacted] revealed a BIMS score of [redacted]/15 indicating Resident #414 had moderately [redacted].	F 658		

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F 658	Continued From page 25 A review of the Pharmacy Consultant Review of medications revealed a recommendation on NJ Exec Order 26.4b1 for an order clarification of NJ Exec Order 26.4b1 BID (two times a day) because the Medication Discharge List from the hospital read NJ Exec Order 26.4b1) BID (twice a day). The review form was signed and dated by the US FOIA (b)(6) on NJ Exec Order 26.4b1 at 09:00 AM. A review of the Electronic Medical Record (EMR) on NJ Exec Order 26.4b1 on 01:54 PM revealed a Medication Discharge List from the hospital dated NJ Exec Order 26.4b1, included NJ Exec Order 26.4b1 2 tab(s) Oral two times a day. A review of the Order Summary Report (OSR) dated with active orders as of NJ Exec Order 26.4b1 revealed that NJ Exec Order 26.4b1 1 tab PO (by mouth) at HS (bedtime) was entered in EMR by Licensed Practical Nurse/ Unit manager (LPN/UM #1) upon Resident #414's admission to the facility. A review of the Medication Administration Record (MAR) revealed that the dose of NJ Exec Order 26.4b1 2 tabs PO BID as per the list of hospital discharged medications upon admission to the facility, was not administered Resident #414 until NJ Exec Order 26.4b1 at 08:00 AM. During an interview with Surveyor #3 on 01/29/2025 at 09:34 AM, Registered Nurse/ Unit Manager (RN/UM #1) described how orders were transcribed during admission. RN/UM #1 stated that that they received a report from the hospital	F 658		

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F 658	Continued From page 26	F 658		

to confirm orders. She said supervisors put in the orders and the night shift would do reconciliation of orders. In the morning, the unit manager or the [US FOIA (b)] would check the admission orders. The [US FOIA (b)] would get an email from [NJ Exec Order 26.4b1]) for review of admission orders. Our pharmacy is linked to [NJ Exec Order]

During an interview with Surveyor #3 on 01/29/2025 at 11:05 AM, Licensed Practical Nurse/ Unit Manager (LPN/UM #1) stated that they would compare the discharge summaries from the hospital that resident came with and the orders in the admission packet medication list. LPN/UM #1 stated that they matched the orders before transcribing into the EMR. LPN/UM #1 further stated that there was a 24-hour turnaround for [NJ Exec Order 2] review. When asked about the [NJ Exec Order 26.4b1] admission order for Resident #414, LPN/UM #1 acknowledged that there was a medication error during the transcription of medications as the transcibed orders did not match hospital medications.

On 01/29/2025 at 12:05 PM, during an interview with Surveyors #1 and #3, the [US FOIA (b)] stated that LPN/UM #1 transcribed an order on [NJ Exec Order 26.4b1] for a different patient.

During an interview with the survey team on 01/31/2025 at 12:15 PM, the [US FOIA (b)] was asked how they ensure that the transcription of orders for admission was accurate. The [US FOIA (b)] stated that the supervisor put in the medications which would be reviewed for reconciliation by the nurse on 11-7 shift. [US FOIA (b)] further stated that [NJ Exec Orde] is integrated with the EMR and that when they receive an [NJ Exec Orde] review, they would immediately

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F 658	Continued From page 27 respond on the same day. A review of the facility provided policy titled Admission Orders dated 05/01/2024, included under Procedure 2. The admitting nurse will call the attending physician and clarify all orders on admission. 3. The admitting orders will be transcribed to the admission Physician Order Sheets (POS) once the orders are clarified or entered into the facility electronic medical record.	F 658		
F 689 SS=J	NJAC 8:39 - NJAC-8:39-27.1(a), 29.3 (a) (6) 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: C/O # NJ 182995 Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to provide NJ Exec Order 26.4b1 for a NJ Exec Order 26.4b1 with a known history of NJ Exec Order 26.4b1 which resulted in the resident NJ Exec Order 26 on NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 3 residents reviewed for NJ Exec Order 26.4b1 (Resident #160). Resident #160, who was NJ Exec Order 26.4b1 with	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 28	F 689		

a known history of NJ Exec Order 26.4b1, NJ Exec Order 26 from the facility on NJ Exec Order 26.4b1. The staff reported last seeing Resident #160 in the dining room between 05:00 PM and 05:30 PM on NJ Exec Order 26.4b1. The resident wore a NJ Exec Order 26.4b1 to their NJ Exec Order 26.4b1 that the physician ordered to be checked for placement and function every shift, and was last checked on NJ Exec Order 26.4b1 at 02:00 PM. On NJ Exec Order 26.4b1 at 07:40 PM, the Registered Nurse (RN #1) reported that the resident was not in their room to receive their medication. Between 08:00 PM and 09:00 PM, the Certified Nursing Assistant (CNA #3) could not locate Resident #160, and he observed that the resident did not eat their dinner. At 09:30 PM, CNA #3 searched the building and alerted RN #1 that Resident #160 could not be found. The facility management and staff began a search for the resident both inside and outside the facility and notified the NJ Exec Order 26.4b1. The NJ Exec Order 2 along with a NJ Exec Order 26.4b1 and NJ Exec Orde searched for Resident #160, and the NJ Exec Order NJ Exec Order 26 the resident on the NJ Exec Order 26.4b in the trees on NJ Exec Order 26.4b1 at 01:45 AM. Resident #160 was immediately sent to the hospital and the resident was admitted with NJ Exec Order 26.4b1 [redacted].

The facility's failure to provide NJ Exec Order 26.4b1 [redacted] to a NJ Exec Order 26.4b1 resident who was at risk for NJ Exec Order 26.4b1 and NJ Exec Order 26 posed a likelihood of NJ Exec Order 26.4b1 [redacted] This resulted in an Immediate Jeopardy (IJ) situation which ran from NJ Exec Order 26.4b1 at 05:30 PM, when Resident #160 was last seen by staff, until NJ Exec Order 26.4b1 at 01:45 AM, when the NJ Exec Order located the resident and sent them to the

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F 689	Continued From page 29 hospital. The IJ was Past Non-Compliance (PNC). The PNC IJ was identified from 12/12/2024 at 05:30 PM, which continued to 12/13/2024 at 01:45 AM, when the resident was found and sent to the hospital for evaluation. The facility was back in compliance when the facility addressed the situation by immediately [redacted] and [redacted] the resident; the resident was sent to the hospital for evaluation; the [redacted] was checked for function; all [redacted] were checked; and all staff were inserviced on the facility's [redacted] protocol. The facility Administration was notified of the PNC IJ on 01/30/2025 at 04:31 PM. The facility submitted an acceptable Removal Plan (RP) on 01/31/2025 at 01:15 PM. The facility team verified the completion of the Removal Plan was 12/30/2024, during the on-site survey on 01/31/2025, and determined the IJ was PNC. The evidence was as follows: A review of a facility policy titled "Elopement" dated 05/01/2024, revealed under the Intent section; It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practical. This is with the intent of not invading privacy but to identify a possible missing resident. A review of the electronic Medical Record (EMR) on 01/30/2025 at 02:20 PM, revealed the following: According to the Admission Record face sheet (an admission summary) Resident #160 was	F 689		

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F 689	Continued From page 30 admitted with diagnoses including but not limited to; NJ Exec Order 26.4b1. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1, revealed Resident #160 had a Brief Interview for Mental Status (BIMS) score of NJ /14 indicating Resident #160 was NJ Exec Order 26.4b1 A further review of the MDS indicated the resident was NJ Exec Order 26.4b1 with no NJ Exec Order 26.4b1 and used a NJ Exec Order 26.4b1. A review of Resident #160's individualized comprehensive care plan (ICCP) included a focus area of at risk for NJ Exec Order 26.4b1 Goals included that the resident will not leave the facility NJ Exec Order 26.4b1 Interventions included to: engage resident in purposeful activity initiated on NJ Exec Order 26.4b1; provide care in a NJ Exec Or and reassuring manner initiated on NJ Exec Order 26.4b1; provide clear simple instructions initiated on NJ Exec Order 26.4b1; and NJ Exec Order 26.4b1 as ordered to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1, check placement and function as ordered initiated on NJ Exec Order 26.4b1 A review of the Order Summary Report revealed a physician's order dated NJ Exec Order 26.4b1 for NJ Exec Order 26. on NJ Exec Order 26.4b1 to check NJ Exec Order 26.4b1 and NJ Exec Order 26.4 every shift. A review of the Medication Administration Record (MAR) dated NJ Exec Order 26.4b1 revealed the physician's order for the NJ Exec Order 26.4b1 was signed as having been checked for placement and function on NJ Exec Order 26.4b1 at 06:00 AM and 02:00 PM.	F 689		

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F 689	Continued From page 31 A review of an NJ Exec Order 26.4b1 Evaluation dated NJ Exec Order 26.4b1, revealed a score of 'NJ E[redacted]' and that the resident was identified for the following risks; a history of NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 the facility without informing staff, resident NJ Exec Order 26.4b1 resident NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 likely to effect the safety or well-being of self/others, and the resident's NJ Exec Order 26.4b1 likely to effect the privacy of others. The evaluation indicated that score of N[redacted] or NJ Exec Order[redacted] indicated a risk of NJ Exec Order 26.4b1 A review of the progress notes (PN) dated NJ Exec Order 26.4b1 at 11:47 PM, included the resident did not have the NJ Exec Order 26.4b1 at this time; resident stated that "I keep it somewhere." A PN dated 11/28/2024 at 11:10 PM, indicated the resident was NJ Exec Order 26.4b1 to oncoming staff; the resident had NJ Exec Order 26.4b1 during this shift. A PN dated NJ Exec Order 26.4b1 at 11:13 PM, revealed 'NJ Exec Order 26.4b1. Noted resident connected with NJ Exec Order 26.4b1 ??? [sic] Made aware US FOIA (b)(6) and shift charge to follow up." A PN dated NJ Exec Order 26.4b1 at 12:03 AM, revealed the resident took off their NJ Exec Order 26.4b1. A PN dated NJ Exec Order 26.4b1 at 05:37 AM, revealed the resident did not have their NJ Exec Order 26.4b1 on. A PN dated NJ Exec Order 26.4b1 at 07:40 PM, indicated the resident was not in their room to receive medication. A PN dated NJ Ex Order 26.4(b)(1) at 02:25 AM, revealed the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234**

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F 689	Continued From page 32 resident was transferred out to the hospital. A review of the facility's Investigation and Summary and Conclusion dated [NJ Exec Order 26.4b1], revealed the following: under the background section: resident had a history of [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] for which interventions have been put into place. Resident wore a [NJ Exec Order 26.4b1]. Under the timeline of Events on [NJ Exec Order 26.4b1] included the following: At approximately (approx) 05:30 PM-06:00 PM, the resident was observed in dining room. At approx 08:00 PM-09:00 PM, CNA #3 went to check on the resident and observed dinner was not touched. At approx 09:30 PM, CNA # 3 initiated a search for the resident. At approx 10:00 PM, management was notified; head count completed; search in the facility and surrounding areas outside of the facility. The outdoor areas were checked by the management team; all doors and [NJ Exec Order 26.4b1] checked by the [US FOIA (b)(6)]) and all [NJ Exec Order 26.4b1] worked properly. At approx 10:15 PM, the family was notified by [US FOIA (b)(6)]). At approx 10:45 PM, the [NJ Exec Order 26.4b1] department was notified, and the [NJ Exec Order] were on site at approximately 11:00 PM. At approx 11:30 PM, the [NJ Exec Order 26.4b1] completed search inside the facility and initiated search outside. The [NJ Exec Order 26.4b] was on-site and not successful. On [NJ Ex Order 26.4(b)(1)]:	F 689		

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F 689	Continued From page 33 At approx 12:30 AM, the search continued with a differen[NJ Exec Order 26.4b1] From approx 12:30 AM-01:30 AM, the management and corporate team continued with search with address on record and other addresses as recommended by the family. During conversation with family, the [family member redacted] mentioned other locations where the resident could be found. At approx 01:45 AM, the resident was transferred to the hospital for evaluation. At approx 02:00 AM, the Department of Health (DOH) was called to report the event. At approx 10:45 AM, the facility called hospital; the resident was admitted to hospital with [NJ Exec Order 26.4b1]. At approx 02:18 PM, the [U.S. FOIA (b) (6)] was notified by the [US FOIA (b)(6)] Under the Interventions in place to prevent future incident included: plan of care reviewed and updated; [NJ Exec Order 26.4b1]; will continue with [NJ Exec Order 26.4b1] ensure list with [NJ Exe] residents placed at front desk; facility wide education completed for [NJ Exec Order 26.4b1] will consider higher level of care for [NJ Exec Order 26.4b1] unit; and all [NJ Exec Order 26.4b1] inspected for safety. A review of a handwritten statement signed by the [U.S. FOIA (b) (6)] on duty on [NJ Exec Order 26.4b1], revealed the following: "I don't know what happened, I do not remember seeing or letting [them] out nor did I hear [NJ Exec Order 26.4b1] going off that night." A review of a handwritten statement signed by the primary nurse (RN #1) dated [NJ Exec Order 26.4b1], revealed that at 09:30 PM, I was informed that [resident's name] was [NJ Exec Order 26.4] and cannot find	F 689		

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F 689	Continued From page 34 them....admitted [to hospital with]: NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 A handwritten statement signed by the US FOIA (b) indicated that on NJ Exec Order 26.4b1 at 10:00 PM, I received a call from the 02:00 PM-10:00 PM supervisor that the resident was missing and could not be located at the facility... A review of a handwritten statement dated NJ Exec Order 26.4b1 at 12:12 PM, signed by the US FOIA (b) as having phone conversation with CNA #3, revealed that CNA #3 stated that at approximately 05:00 PM-06:00 PM, he observed the resident in the dining room sitting. At approximately 08:00 PM-09:00 PM, CNA #3 went to check the resident in their room, and he observed the resident's dinner tray was not touched. At 09:30 PM, CNA #3 initiated a search for the resident, and then informed the nurse and the US FOIA (b)(6) . During an interview with the survey team on 01/30/2025 at 01:17 PM, the US FOIA (b)(6)) revealed the following information: The US FOIA (b) confirmed Resident #160 NJ Exec Order 2 on NJ Exec Order 26.4b1, that during the evening shift, the resident was last seen at 05:30 PM in the dining room. The US FOIA (b) stated staff realized between 08:00 PM-09:00 PM, the resident NJ Exec Order 26.4b1 and staff made a facility-wide announcement to NJ Exec O staff to NJ Exec Order 2 the whole facility for Resident #160. The US FOIA (b) confirmed the resident was not found in the facility during the search. The US FOIA (b) confirmed Resident #160 was an NJ Exec Order 26.4b1 risk; their NJ Exec Order 26.4b1 ; the resident had a NJ Exec Order 26.4b1 they	F 689		

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F 689	Continued From page 35	F 689		

were on the risk for NJ Exec Order 26.4b1 list at the front desk; and it was included in their ICCP. The US FOIA (b) stated the facility checked the resident's NJ Exec Order 26. every shift for placement and function and that the facility had a NJ Exec Order 26.4b1 that the nurse was responsible for using. The US FOIA (b) acknowledged that the last time the resident's NJ Exec Order 26.4b1 was checked on NJ Exec Order 26.4b1, was at at 06:00 AM. (This contradicted the MAR which was signed as checked on NJ Exec Order 26.4b1 at 02:00 PM) The US FOIA (b) stated when the resident was missing, the US FOIA (b)(6) who then notified all the department heads and the regional staff.

The US FOIA (b)(6) stated we (management team) did another sweep of the building and the outside perimeter, and we were NJ Exec Order 26.4b1 Resident #160 so we called the NJ Exec Order who arrived at the facility and searched both inside and outside. The US FOIA (b)(6) continued that the NJ Exec Orde took a piece of Resident #160's clothing from their room, and had a NJ Exec Order 26.4b1 for the resident's NJ Exec Orde and the NJ Exec Order 26.4b1 for the resident. The US FOIA (b)(6) stated the US FOIA (b)(6) went in his car to ask local businesses if they saw Resident #160, and the facility contacted the resident's emergency contact to see if they knew where the resident would go with no success. The US FOIA (b)(6) stated the NJ Exec Order then called for a NJ Exec Order 26.4b1 NJ Exec O and NJ Exec Order 2 and the NJ Exec Order located the resident on the property in the back left side to the corner of the fence line. The US FOIA (b)(6) said that you can not get out of the fence back there; that there were trees and brush/bushes. The US FOIA (b)(6) stated that you needed to go into the tree line to actually see the corner of the fence where the resident was located. The US FOIA (b)(6) stated that a US FOIA (b) who was familiar with the resident from a

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 689	Continued From page 36	F 689		

previous facility where Resident #160 had NJ Exec Order 26 from said the resident NJ Exec Order 26.4b1 and that the facility should check there. The US FOIA (b)(6) stated at that time, the facility informed the NJ Exec Order of this because the facility was unable to check outside since the NJ Exec Order instructed the facility to stay inside so their NJ Exec Order 2 would not interfere with the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that the NJ Exec Order NJ Exec Order 26 Resident #160 in the NJ Exec Orde The NJ Exec Order called the ambulance who transported the resident to the hospital and the resident was admitted for two days for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.

When questioned how Resident #160 NJ Ex Order 26.4 NJ Ex Orde the building, the US FOIA (b)(6) replied that the elevator doors opened if you had a NJ Exec Order 26.4b1, but the elevator would not move, it NJ Exec Order 26.4b1 The US FOIA (b)(6) stated that the facility still did not know how Resident #160 NJ Ex Order 26.4(b)(1) because when the resident returned from the hospital, their NJ Exec Order 26.4b1 . The US FOIA (b)(6) stated that only the NJ Exec Order 26.4b1 doors were NJ Exec Order 26.4b for the NJ Exec Order 26.4b1, and the NJ Exec Orde was loud enough to be heard from the elevator at the nurse's station.

The US FOIA (b)(6) stated at the time of the incident, the nurses were busy administering medication and the CNAs were doing second incontinent care for the residents. The US FOIA (b)(6) said "We tried to watch the video, hard to see, but [the resident] NJ Exec Order 26.4b ." The US FOIA (b)(6) stated the US FOIA (b)(6) was there until 08:00 PM, and we asked her if she saw Resident #160, but the US FOIA (b)(6) denied it. The US FOIA (b)(6) stated they were able to tell on the video the time the resident left the building, but he did not "recall the time," and when asked if it was after 08:00 PM, the

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 689	Continued From page 37 US FOIA (b)(6) could not recall. On 01/30/2025 at 02:23 PM, the surveyor requested to watch the video from NJ Exec Order 26.4b1, and the US FOIA (b)(6) said "it only stores for 72 hours, and we couldn't tell what time [the resident] left." This contradicted the US FOIA (b)(6) previous statement that the facility was able to determine what time the resident NJ Exec Order 26 from the video, but he could not "recall" the time. During an interview with the surveyor on 01/30/2025 at 02:28 PM, CNA #2 stated that they cared for Resident #160 frequently, but they were not in the facility on NJ Exec Order 26.4b1, when the resident NJ Exec Order 26 CNA #2 stated the resident was 'NJ Exec Order 26.4b1 regarding NJ Exec Order 26.4b1 and that they often NJ Exec Order 26.4b1. CNA #2 stated that Resident #160 NJ Exec Order 26.4b1, so the resident NJ Exec Order 26.4b1 and sat at the nurse's station 'NJ Exec Order 26.4b1." CNA #2 stated that Resident #160 talked about NJ Exec Order 26.4b1; that they went on the elevator and the NJ Exec Order 26 and staff had to NJ Exec Order 26.4 the resident and NJ Exec Order 26 them with things to do. During a telephone interview with Surveyor #5 on 1/30/2025 at 02:00 PM, the US FOIA (b)(6) said she worked at the facility on NJ Exec Order 26.4b1, from 04:00 PM-08:00 PM, and she did not know what happened. The US FOIA (b)(6) denied seeing Resident #160 that night; that there were NJ Exec Order 26.4b. The US FOIA (b)(6) denied hearing an NJ Exec Orde go off at the NJ Exec Order 26.4b1, and stated she was unfamiliar with the NJ Exec Order 26.4b1. On 01/30/2025 at 02:30 PM, two surveyors along	F 689		

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 689	Continued From page 38	F 689		

with US FOIA (b)(6) walked the property to see where Resident #160 was located. The following observations and interviews occurred:

The surveyors and US FOIA (b)(6) walked left out of the building and toward the rear of the property. Behind the building there was an NJ Exec Order 26.4b1 that ran the length of the property, and beyond the vinyl fence were additional grounds that were contained by a chain link fence. That additional area was approx 50 yards (yds) wide with an approx length of 150 yds. The night of the NJ Ex Order 26.4(b)(1) the US FOIA (b)(6) stated that he (the US FOIA (b)(6) walked to the vinyl fence on the rear right side where an 8 ft section of vinyl fence was missing and looked around and stated it was very dark and the US FOIA (b)(6) was unable to locate the resident. The US FOIA (b)(6) stated there were bushes and small trees that made it harder to see, so he returned to the front of the building where he overheard a NJ Exec Order 26.4b1 say they may have NJ Exec Order 26.4b1, and the NJ Exec Order 26 began running behind the building and the US FOIA (b)(6) followed them. The US FOIA (b)(6) stated it was NJ Exec Order 26.4b1 and the trees had their leaves and were much bulkier and made it harder to see the area. The NJ Exec Order 26.4b1 . The US FOIA (b)(6) stated the administrative team were assuming the resident NJ Exec Order 26.4b1 .

When the surveyors approached the vinyl fence, they observed that the gate which had a hinge

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F 689	Continued From page 39	F 689		

latch that was not closed, and the gate appeared to be stuck open with an approximately one foot wide opening to pass through. At that time, the US FOIA (b)(6) attempted to see if the gate would latch and was unable to do so and stated," I could make it close". When asked, the US FOIA (b)(6) could not recall if the gate was opened the night the resident NJ Exec Order 26

The area behind the gate enclosed in the chain link fence had tall grasses and bushes and trees that sloped down into a valley in the middle similar to a retention basin with black rocks in the middle. The area sloped down sharply toward the middle and was uneven with thorn bushes and brambles. The US FOIA (b)(6) stated that he believed the resident NJ Ex Order 26.4(b)(1) wearing shoes, gray sweatpants, and a white t-shirt. The US FOIA (b)(6) stated the resident was NJ Exec Order 26.4b1 . The US FOIA (b)(6) stated the resident was NJ Exec Or and NJ Exec Order 26.4b1 When asked if the resident had NJ Exec Order 26.4b1 , and the US FOIA (b)(6) stated that he did not do a NJ Exec O at the time because the NJ Exec Order were in charge of the situation, and the facility was told to step away.

The surveyor observed the closest exit door from the facility to that area was from the First-floor rehabilitation unit that connected to a sidewalk that led to the area the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that door was ruled out as where the resident NJ Exec Order 2 since no one reported hearing an NJ Exec Order 3 and the US FOIA (b)(6) confirmed if the resident left through the main entrance, the NJ Exec Order 26.4b1 NJ Exec Orde would have NJ Exec Order 26.4b1

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 689	Continued From page 40 During a telephone interview with Surveyor #3 on 01/31/2025 at 10:32 AM, RN #1 said that she recalled the incident, but she could not recall the exact dates and times. RN #1 said she believed that she was the supervisor that evening. At that time, the Surveyor confirmed with RN #1 that the Nursing Note was written by her on [NJ Exec Order 26.4b] at 07:40 PM, that indicated Resident #160 was not in their room to receive medication. RN #1 stated that she covered the medication cart as needed, and when the surveyor questioned what RN #1 did after she identified Resident #160 was not in their room, RN #1 stated she continued to administer medication to other residents. RN #1 stated she recalled seeing Resident #160 at the nurse's station around dinner time at maybe 06:00 PM. RN #1 recalled Resident #160 was [NJ Exec Order 26.4b1] RN #1 also recalled seeing Resident #160 in the dayroom, but she could not recall the time. RN #1 stated that a CNA (CNA #3) informed her that the resident's dinner plate was untouched as he was collecting trays (unable to recall exact time), and we started searching and I immediately notified the staff and called the [US FOIA (b)(6)] RN #1 stated the [NJ Exec Order] were called and the inside and outside of the [NJ Exec Order 26.4b1]. The surveyor asked if RN #1 recalled seeing the resident's meal tray when they attempted to administer medications, and she responded, no, that the resident often [NJ Exec Order 26.4] their meal and would eat it later. Surveyor #3 asked RN #1 if they made additional attempts to administer Resident #160's medications, and the RN stated that typically if a resident was not in their room for medication, she looked for them or she went back to give them medication. RN #1 stated that CNA #3 had [NJ Exec Order 26] her about Resident #160 shortly after. RN #1 confirmed Resident #160 wore a	F 689		

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234**

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F 689	Continued From page 41 NJ Exec Order 26.4b1 that was tested daily. During an interview with Surveyor #1 on 01/31/2025 at 11:17 AM, the US FOIA (b)(6) was asked if the stairways were NJ Exec Order 26.4b1 and the US FOIA (b)(6) confirmed they were NJ Exec Order 26.4b1 including for a NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that the therapy doors to the outside had a NJ Exec Order 26.4b1, magnetic lock and were on a keypad. The US FOIA (b)(6) said there was no problem with the NJ Exec Order 26.4b1 system at the time the resident NJ Exec Order 26.4b1 The acceptable Removal Plan on 01/31/2025 at 01:16 PM, indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including: staff initiated the NJ Exec Order 26.4b1 protocol and contacted the NJ Exec Order 26.4b1 Resident #160 was NJ Ex Order 26.4(b)(1) the facility, assessed, and transported to the hospital for evaluation; Resident #160's plan of care was updated to include NJ Exec Order 26.4b1; Resident #160's NJ Exec Order 26.4b1 was checked for function; the facility's NJ Exec Order 26.4b1 was checked for function; and all staff were educated on the facility's NJ Exec Order 26.4b1 protocol. The facility self-corrected the deficient practice and it was determined that the IJ was Past Non-Compliance (PNC); that the facility corrected their non-compliance on 12/30/2024. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 01/31/2025.	F 689		
F 812 SS=D	NJAC 8:39-27.1(a) Food Procurement,Store/Prepare/Serve-Sanitary	F 812		3/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 812	Continued From page 42 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 01/29/2024 at 09:23 AM during a tour of the second-floor pantry the surveyor observed no thermometer in the freezer. There were 5 plastic containers of food in the freezer. The temperature log was marked with NA for the whole month of January.	F 812	Based on observation, interview, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. A thermometer was placed in the freezer on 1/29/25. A new temp log was placed. All items inside the freezer were discarded. b. All food items dated previously to 1/26/25 were discarded immediately. c. Education was completed by	

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	315514	A. BUILDING _____ B. WING _____	C 01/31/2025

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F 812	Continued From page 43 During that same tour the surveyor observed a paper wrapped sandwich labeled with a resident's room number and dated for 01/25/2025 in the refrigerator. During an interview on 01/29/2025 with the surveyor, the US FOIA (b)(6) said that night shift nursing staff were responsible for the cleaning the refrigerator and checking the temperature. The US FOIA (b) said she was not sure how long food was allowed to be in the refrigerator and she would have to check the policy. The US FOIA (b) also said that she didn't think the freezer needed a thermometer unless there was food in there. During an interview on 01/30/2025 at 04:12 PM with the surveyor, the US FOIA (b)(6) said per our policy there should have been a thermometer in the freezer. The US FOIA (b)(6) also said that food brought in the facility should only be in the refrigerator for 72 hours and that sandwich should have been thrown out. A review of a facility provided policy dated 05/01/204, titled "Food Handling- Refrigerators" revealed under "Procedures" that, "6. Temperatures of refrigerators and freezers will be monitored daily and documented." A review of a facility provide policy dated 05/01/2025, titled "Food Brought by Family and Visitors" revealed that, "All foods belonging to residents must be labeled with the resident's name, the item, and the "use by" date. Foods that are not labeled with "use by date" will be dated upon receipt and discarded within three days. Foods brought from home without an expiration	F 812	US FOIA (b)(6) on 2/5/25 with nursing staff to ensure temperature logs are completed daily and to ensure a thermometer is placed inside the freezer and fridge at all times. 2. Identification of residents who have the potential to be affected by the same deficient practice: All residents in the vent unit have the potential to be affected by this deficient practice. 3. Systemic changes to ensure that the deficient practice does not recur: a. The Food Service Director or designee will check daily to ensure location of the thermometer in the freezer and fridge. b. The Food Service Director or designee will check all food items daily for labeling and to ensure all items are discarded if the items are past the 72-hour period. 4. Monitoring of corrective actions: a. The Administrator or designee will audit the temperature logs in the first floor and second floor pantries 2 times a week for 4 weeks and them monthly for 5 months to ensure compliance. The audit will include temperature logs, presence of thermometer in the freezer and fridge and labeling of food items. b. Audit findings will be reviewed during the QAPI meetings quarterly for 6 months and corrective actions will be implemented as needed.	

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F 812	Continued From page 44 date will be discarded after 3 days." N.J.A.C. 8:39-17.2(g)	F 812		
F 880 SS=D	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 §483.71 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	F 880		3/17/25

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F 880	Continued From page 45 reported; (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, review of medical records, and review of other facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene practices for 3 of 3 staff observed during medication pass and lunch service, respectively	F 880	Based on observation, interview, review of medical records, and review of other facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene practices for 3 of 3 staff observed during medication	

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F 880	Continued From page 46 b.) implement infection control measures for the handling and storage of [NJ Ex Order 26.4(b)(1)] equipment for 3 of 3 residents reviewed for [NJ Ex Order 26.4(b)(1)] care (Residents # 23, #315, and #413). This deficient practice was evidenced by the following: 1. On 01/28/2025 at 08:06 AM, Surveyor #1 observed Licensed Practical Nurse (LPN) #4 during medication pass. LPN#4 did not perform hand hygiene including not using Alcohol Based Hand Rub (ABHR) after administration of medications. On 01/28/2025 at 08:20 AM, Surveyor #1 observed LPN #4 administer medication to Resident #82. LPN #4 did not perform hand hygiene prior to administering the medications. During an interview with Surveyor #1 on 01/28/2025 at 08:27 AM, LPN #4 was asked about hand hygiene practices during medication pass. LPN #4 stated that she should have practiced hand hygiene before and after medication pass. LPN #4 further stated that they (staff) have received education about proper hand hygiene during medication pass. 2.) On 01/28/2025 at 12:09 PM, Surveyor #1 observed Certified Nursing Assistant (CNA) #1 assist Resident #414 in the 1st floor dining room during lunch service. CNA #1 opened a carton of fruit juice, poured the juice in a cup and helped the resident bring the cup to their mouth. After drinking, CNA #1 assisted Resident #414 with their meal. CNA # 1 did not offer nor assist Resident #1 to perform hand hygiene prior to eating. After assisting the resident, CNA #1 was	F 880	pass and lunch service, respectively b.) implement infection control measures for the handling and storage of [NJ Exec Order 26.4b1] equipment for 3 of 3 residents reviewed for [NJ Exec Order 26.4b1] care (Residents # 23, #315, and #413). 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. LPN#4 and all qualified nursing staff was educated by DON on 1/29/2025 about infection control practices, and a hand wash competency was completed on 1/29/2025. b. CNA #1 and all nursing staff were educated by DON on 1/29/2025 about infection control practices during meal service. An emphasis was made on hand hygiene before assisting residents with meals and assisting residents with hand hygiene before meal service. c. The hospice company was notified on 2/13/2025 about the infection control deficient practice. Facility requested infection control education for hand hygiene during meal service for hospice aids (HA) providing care in our facility. d. [NJ Exec Order 26.4b1] was changed immediately. Education was completed by [US FOIA (b)] on 2/17/2025 for all nursing staff regarding oxygen tubing placement in a storage bag when not in use. Nursing was instructed to discard tubing if tubing comes in contact with floor or garbage bin. 2. Identification of residents who have the potential to be affected by the same deficient practice:	

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F 880	Continued From page 47 observed to sanitize their hands with alcohol-based sanitizer. Surveyor #1 asked CNA #1 if prior to eating should the residents be offered an opportunity to perform hand hygiene. CNA #1 responded she should have wiped the resident's hands with the sanitizing wipes before helping the resident eat. 3.) On 01/28/2025 at 12:10 PM, Surveyor #1 observed a US FOIA (b)(6) assist Resident #68 in the 1st floor dining room during lunch meal. The US FOIA did not offer nor assist Resident #68 to perform hand hygiene prior to eating. Surveyor #1 asked the US FOIA together with CNA #1 the US FOIA stated that they should have wiped the resident's hands with the sanitizing wipes before helping the residents eat. 4.) On 01/27/2025 at 06:33 PM, Surveyor #1 observed Resident #23's bagged NJ Exec Order 26.4b1 hanging low from the side table's handle with the entire bag touching the floor. At that time, Surveyor #1 interviewed LPN #6 and showed them the bag touching the floor. LPN #6 stated the bag should not be touching the floor. 5.) On 01/29/2025 at 01:10 PM, Surveyor #1 observed Resident #413 lying in bed. Resident #413's NJ Exec Order 26.4b1 was wrapped around the NJ Exec Order 26.4b1 touching the trash in the trash can located beside the bed. The NJ Exec Order 26.4b1 was noted to be off. Surveyor #1 showed LPN #3 the NJ Exec Order 26.4b1. LPN #3 stated the NJ Exec Order 26.4b1 should have been in the bag, pointing to a labeled plastic bag on the side table. LPN #3 took the NJ Exec Order 26.4b1 with the NJ Exec Order 26.4b1 and said they were going	F 880	All residents in the vent unit have the potential to be affected by this deficient practice. 3. Systemic changes to ensure that the deficient practice does not recur: a. The Infection Preventionist will educate all qualified nursing staff regarding hand wash during medication administration on hire and annually. b. The QAD or designee will observe dining room meal service to ensure CNAs assist residents with hand hygiene before meal service. c. Hospice Aids will receive hand hygiene education during meal service prior to assisting residents with meals. d. The Infection Preventionist or designee will verify placement of the oxygen tubing during infection control rounds daily. 4. Monitoring of corrective actions: a. The Infection Preventionist will observe 1 nurse per week for 4 weeks and monthly for 5 months during medication administration to ensure proper hand hygiene. b. The QAD or designee will observe 1 CNA per week for 4 weeks and the monthly for 5 months during meal service to ensure residents are assisted with hand hygiene. c. The QAD or designee will observe 1 HA per week for 4 weeks and the monthly for 5 months during meal service to ensure proper hand hygiene. d. The Infection Preventionist or designee will audit 2 residents weekly for 4 weeks and then monthly for 5 months to ensure proper storage and placement of	

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F 880	Continued From page 48 to replace it. On 01/27/2025 at 06:44 PM, during the initial tour, Surveyor #2 observed Resident # 315 sitting in a wheelchair in his/her room with the NJ Exec Order 26.4b1 laying on the floor not labeled. A review of Resident # 315's Admission Record revealed the resident was admitted to the facility with diagnoses including but not limited to: [redacted] A review of Resident #315's Medication Administration Record (MAR) revealed a physician's order for NJ Exec Order 26.4b1 [redacted] A review of Resident #315's Treatment Administration Record (TAR) revealed a physician's order to change NJ Exec Order 26.4b1 if obstructed, compromised and damaged as needed every 24 hours as needed. There was no documentation that the NJ Exec Order 26.4b1 had been changed per the TAR. During an interview on 01/29/2025 at 12:36 PM with Surveyor #2, the Licensed Practical Nurse (LPN) # 2 said that she thinks NJ Exec Order 26.4b1 gets changed weekly on 3rd shift, and if gets dirty or drops on the floor. LPN #2 also said that the [redacted] should be labeled and dated when NJ Exec Order 26.4b1 When if there was documentation of NJ Exec Order 26.4b1, LPN #2 said I am not	F 880	oxygen tubing. e. Audit findings will be reviewed during the QAPI meetings quarterly for 6 months and corrective actions will be implemented as needed.	

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F 880	Continued From page 49 sure maybe in a note. During an interview on 01/29/2025 at 12:56 PM with Surveyor #2, the[US FOIA (b)(6) redacted] said that [NJ Exec Order 26.4b1 redacted] used to be changed on a weekly basis, now it is if compromised, on the floor, or damaged. [NJ Exec Order 26.4b1 redacted] should be dated and labeled and documented in the MAR when it is changed. When asked when Resident # 315's [NJ Exec Order 26.4b1 redacted] was last changed the [redacted] looked in the MAR and replied, "I don't know it wasn't documented". During an interview on 01/30/2025 at 04:12 PM with Surveyor #2 the [US FOIA (b)(6) redacted]) said that Resident #315 is known for taking the [redacted] off and they always find it on the floor. The [redacted] said that the [NJ Exec Order 26.4b1 redacted] should be changed for infection control when found on the floor and documented in the MAR or TAR. A review of the facility on 01/28/2025 at 10:14 AM, titled Hand Hygiene Policy dated 04/01/2024, did not include hand hygiene before and after medication pass. A further review of the policy indicated under Procedure: 3. The Centers for Medicare and Medicaid State Operations Manual indicates that hand hygiene should be performed ...d. Before and after assisting a resident with meal. A review of a facility provided policy on Respiratory Equipment dated 05/01/2024 under section Procedure and Routine Schedule Changes revealed 3. Statement ... Nebulizer masks are stored in a plastic bag when not in use, or as per resident's preference. 9. Statement ... Nasal cannulas are stored in a plastic bag when not in use, or as per resident's preference,	F 880		

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F 880	Continued From page 50 Nasal cannulas changed when damaged, visibly soiled and PRN ..." 8:39-19.4 (k)	F 880		

New Jersey Department of Health

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H5750	8:43E-13.4(b) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This REQUIREMENT is not met as evidenced by: Based on interviews, and review of the Electronic Medical Record (EMR), as well as other facility documentation, it was determined that the facility failed to complete in its entirety, the New Jersey Universal Transfer Form (NJUTF) when a resident was transferred to the hospital for 1 of 3 residents reviewed for hospital transfers, (Resident #89). This deficient practice was evidenced by the following: Reference: New Jersey Hospital Association "Provider Resources" Section 6: The NJ Universal Transfer Form (UTF) must be used by all licensed healthcare facilities and programs when the patient is transferred from one care setting to another. A review of the Electronic Medical Record on 01/28/2025 10:01 AM, revealed the following:	H5750	Based on interviews, and review of the Electronic Medical Record (EMR), as well as other facility documentation, it was determined that the facility failed to complete in its entirety, the New Jersey Universal Transfer Form (NJUTF) when a resident was transferred to the hospital for 1 of 3 residents reviewed for hospital transfers, (Resident #89). 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. The Universal Transfer Form (UTF) was located, and missing sections were discussed with physician. b. Education was completed by DON on 2/6/25 for all nurses to ensure completion of the UTF entirely before transferring a resident to the hospital. 2. Identification of residents who have	3/17/25

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

Electronically Signed | 02/23/25

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H5750	Continued From page 1 According to the Admission Record, Resident # 89 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] A review of a progress note dated NJ Ex Order 26.4(b)(1) timed at 07:07AM, pt (patient) received in chair at nurse's station. PT difficult to arouse at 5am. NJ Exec [redacted]) administered. NP (Nurse Practitioner) was made aware. NP ordered NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 [redacted] PT had lots of NJ Exec Order 26.4b1 in the NJ Exec Order and NJ Exec Order 26.4b1. 911 was called and PT was transferred to hospital. NP aware and family notified. A review of the NJUTF sent with the resident to the hospital on NJ Exec Order 26.4b1 revealed the following: Section 1, 2, 6, NJ Exec Ord 12, 13, 14, 15, 16, 17, 18, 19, 21, 22, 25, 26, 27 were not completed in their entirety or were left blank. During an interview with the survey team on 01/30/2025 at 09:41 AM, the surveyor asked the Director of Nursing (DON) we print out the NJUTF from EMR and fill it out by hand. The DON confirmed Yes, we fill in all areas before sending resident to the hospital.	H5750	the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice. 3. Systemic changes to ensure that the deficient practice does not recur: a. The nursing supervisor or designee will review completion of the Universal Transfer Forms for all hospital transfers before transfer. 4. Monitoring of corrective actions: 1. The Director of Nursing of designee will audit 3 Universal Transfer Forms weekly and then monthly for 5 months to ensure thorough completion. 2. Results of the monitoring will be reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical	H5790		3/17/25

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EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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H5790	Continued From page 2 record. This REQUIREMENT is not met as evidenced by: Based on interview and review of the Electronic Medical Record (EMR) it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer form (NJUTF) as part of the medical record for 1 of 3 residents reviewed for hospitalizations (Resident #22). This deficient practice was evidenced by the following: The surveyor reviewed the EMR on 01/28/2025 at 11:31 AM, as follows: According to the Admission record Resident #22 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the progress notes revealed the following; On 3/27/2024 at 08:35 AM, Resident #22 presented with NJ Exec Order 26.4b1 Resident received medications and was on NJ Exec Order 26.4 Resident #22's NJ Exec Order 26 wanted resident to be sent out due to NJ Exec yesterday and check if it was due to history of NJ Exec Order 26.4b1 Resident is going out in NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 NJ Exec Order 26 was notified.	H5790	Based on interview and review of the Electronic Medical Record (EMR) it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer form (NJUTF) as part of the medical record for 1 of 3 residents reviewed for hospitalizations (Resident #22). 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. The Universal Transfer Forms (UTF) missing was discussed with the physician. b. Education was completed by DON on 2/6/25 for all nurses to ensure a copy of the UTF is placed in the residents chart after hospital transfer. 2. 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. 3. Systemic changes to ensure that the deficient practice does not recur: a. The nursing supervisor or designee will ensure a copy of the UTF is made and placed in the residents chart to be uploaded to the electronic health record	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01001	A. BUILDING: _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

(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
H5790	Continued From page 3 On 4/6/2024 at 12:00, Resident NJ Exec Order 26.4b1 . Resident had NJ Exec Order 26.4b1 of NJ Exec Order 26.4b and NJ Exec Order 26.4b1 of NJ Exec Order 26.4b since yesterday morning. Spoke to Nurse Practioner (NP), received order to complete a NJ Exec Order 26.4b1 if NJ Exec Order 26.4b continued, which was rendered and sent out. Approximately 11:15, nurse went in to patient room to check on him, and he/she was on the floor in front of his/her personal closet, with NJ Exec Order 26 NJ Exec Order 26 present. Upon asking what happen, stated she had just walked in and seen him/her on the floor. Resident stated he/she was trying to get the door to his/her NJ Exec Order 26.4 Patient was NJ Exec Order 26.4b1 , and had a noticeable new abrasion on his/her NJ Exec Order 26.4b1 pt was asked if he NJ Exec Order 26.4b1 and stated no. Dr. (doctor) was contacted at this time and received orders to send to hospital. On 04/11/2024 at 05:40 PM, Resident Received sitting in front of nurses station, resident has been 1 on 1 since NJ Exec Order 26.4b1, change of NJ Exec Order 26.4b1 NJ Exec Order 26.4b1, resident has NJ Exec Order 26.4b1 since early am, NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 of NJ Exec since 2pm, NJ Exec Order 26.4b1. Contacted Dr. to make aware of current status and was giving order to send out for further evaluation. Responsible party NJ Exec Order 26 made aware. On 4/14/2024 05:24 PM, resident transferred to hospital via NJ Exec Order 26.4b1 Resident was NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 at 04:45 PM. NJ Exec Order 26.4b1 Resident NJ Exec Order 26.4b1 when NJ Exec Order 26.4b1 was provided. Resident NJ Exec Order 26.4b1 of NJ Exec Order and NJ Exec Order 26.4b VS (vital signs) as follows:	H5790	(EHR). 4. Monitoring of corrective actions: 1. The Director of Nursing of designee will audit 3 hospital transfer weekly for 4 weeks and then monthly for 5 months to ensure a copy of the UTF is present in the physical chart or uploaded to the EHR. 2. Results of the monitoring will be reviewed during QAPI meetings quarterly for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

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	01001	A. BUILDING: _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

(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
H5790	Continued From page 4 NJ Ex Order 26.4, NJ Exec Order 26.4b1 Resident NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 but NJ Exec Order 26.4b1. At 05:00 PM, Resident NJ Exec Or and NJ Exec Order 26.4b to NJ Exec Order 26 only, NJ Exec Order 26.4b1 but with continued NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Dr., supervisor, and NJ Exec Order 26 notified of incident. Resident sent to the hospital. On 05/07/2024 at 03:39 AM, Resident noted sitting at nurses' station. NJ Exec Order 26.4b1 noted 1 NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 placed at NJ Exec Order 26.4b1 Resident remained in NJ Exec Order 26.4b state. Resident sent to ER for Evaluation. Call placed to Physician and Emergency contact on file. On 08/15/2024 at 07:46 AM, Resident had NJ Exe [redacted]. Call placed to Physician and order received for resident to be sent to ER for evaluation. Call placed to emergency contact on file making them aware of transfer. Resident sent to hospital. The facility was unable to provide the NJUTF for resident's discharge to the hospital on the aforementioned dates. During an interview with the surveyor on 01/30/2025 at 09:40 AM, the Vice President of Clinical Services (VPCS) and the Director of Nursing (DON) in the presence of survey team was completed. The DON stated they were waiting on the NJUTF for the resident from the hospital and they (the facility) didn't have them in the chart. The DON when asked if the facility was	H5790		

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EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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H5790	Continued From page 5 required to maintain a copy of the NJUTF here in the facility, the DON stated yes, and then confirmed there were no copies here. The nurse must complete the form in its entirety. We print the form from the EMR and fill in vitals signs and fill in all the blanks before sending the resident to hospital. We should place a copy of the form in the medical record.	H5790		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of other 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 1.) For the 2 weeks of staffing prior to survey from 01/21/2025 to 01/25/25, the facility was deficient CNA staffing for residents on 15 of 15-day shifts, and 2.) For the week of complaint staffing from 12/12/24 to 12/13/24, the facility was deficient in CNA staffing for residents on 1 of 2-day shifts. Findings include: 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	S 560	Based on interviews and review of other 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. 1. Corrective Actions Accomplished for residents found to have been affected by the deficient practice: a. 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 hirs CNAs, direct nursing staff include aggressively running ads through various social media platforms, utilizing of employment	3/17/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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S 560	Continued From page 6 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: 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 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 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. As per the Nurse Staffing Reports completed by the facility for weeks of 01/21/2025 to 01/25/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/12/25 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/13/25 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/14/25 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/15/25 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/16/25 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/17/25 had 13 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/18/25 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs.	S 560	application websites and fostering partnerships with recruitment and employment agencies. 2. Identification of residents who have the potential to be affected by the same deficient practice: a. All residents have the potential to be affected by this situation. 3. Systemic changes to ensure that the deficient practice does not recur: a. Facility recruitment and retention strategies and efforts will remain 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. " Make attempts to attract overtime or PRN 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 medial platforms and employment application websites. " Flexible shifts and schedules. " Work with CNA schools to recruit new graduates. " The administrator, staffing coordinator and nursing leadership will meet daily to review/monitor CNAs schedules to ensure ratios are met. CNA staffing needs will be posted on the agency website. 4. Monitoring of corrective actions: a. The HR Director or designee will provide weekly reports to the Administrator regarding all efforts made to try to comply with the States staffing ratios. b. Reports will be presented to the QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	01001	A. BUILDING: _____ B. WING _____	C 01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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S 560	Continued From page 7 -01/19/25 had 14 CNAs for 119 residents on the day shift, required at least 15 CNAs. -01/20/25 had 14 CNAs for 118 residents on the day shift, required at least 15 CNAs. -01/21/25 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -01/22/25 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -01/23/25 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -01/24/25 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/25/25 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. For the week of Complaint Staffing from 12/12/24 to 12/13/24, the facility was deficient in CNA staffing for residents on 1 of 2-day shift as follows: -12/13/24 had 12 CNAs for 116 residents on the day shift, required at least 14 CNAs. During an interview with the surveyor on 01/30/2025 at 12:20 PM, the Staffing Coordinator (SC) stated that she follows the mandated staffing ratios; Day shift 1:8 (1 CNA to 8 Residents, Evening shift 1:10, and Night shift 1:14. The SC added that when they have call outs, the facility offers bonuses and bargains with the staff to pick up additional shifts as well as contacting agencies for staff. The SC stated that the team meets daily to discuss retention and hiring; "We are always looking to hire." During an interview with the surveyor on 01/31/2025 at 11:52 AM, the Licensed Nursing Home Administrator stated that the facility meets the acuity needs for the facility. He added that he	S 560	committee quarterly for one quarter. The QAPI committee will determine if further reports are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234**

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S 560	Continued From page 8 is aware of the state regulations; day shift 1:8, evening shift 1:10, and night shift 1:14. A review of a facility policy titled, "Staffing," dated 5/1/24, under "Purpose," This policy ensures compliance with the current New Jersey state mandates, rules and regulations governing staffing in skilled nursing facilities. The goal is to provide adequate staffing levels for high-quality resident care and regulatory compliance.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315514 Y1	A. Building B. Wing Y2	3/31/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 03/17/2025	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 03/17/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
1/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315514 Y1	A. Building B. Wing Y2	3/31/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0582	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	03/17/2025	LSC	03/17/2025	LSC	03/17/2025
ID Prefix F0609	Correction	ID Prefix F0658	Correction	ID Prefix F0812	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	03/17/2025	LSC	03/17/2025	LSC	03/17/2025
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/17/2025	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	
1/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01001 (Y1)	A. Building B. Wing (Y2)	3/31/2025 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix H5750 Reg. # 8:43E-13.4(b) LSC	Correction Completed 03/17/2025	ID Prefix H5790 Reg. # 8:43E-13.4(d) LSC	Correction Completed 03/17/2025	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 1/31/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01001 Y1	A. Building B. Wing Y2	3/31/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/17/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 1/31/2025	☐ 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
	315514	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD** **EGG HARBOR TOWNSHIP, NJ 08234**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/30/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/30/25 and the facility and the facility 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. Excel Care at Egg Harbor is a one story, Type II protected building that was built in 2012. The facility is divided into four smoke compartments. The diesel generator powers 65% of the building per the Maintenance Director. The number of occupied beds was 118 out of 120.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT	K 222		3/7/25

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

Electronically Signed | 02/21/2025

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
	315514	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD** **EGG HARBOR TOWNSHIP, NJ 08234**

(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 222	Continued From page 1 LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies	K 222		

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K 222	Continued From page 2 installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doors with delayed egress locking devices activated an audible sound when the door was pushed to open in accordance with NFPA 101 (Life Safety Code 2012 Edition) Chapter 7.2.1.6.1.1(3). This deficient practice had the potential to affect 55 residents. Findings include: An observation on 01/30/25 at 2:33 PM revealed the 15-second delayed egress locking system for the exit door located in the Activity Room adjacent to Therapy, did not activate an audible signal when the US FOIA (b)(6) applied force to the release device. During an interview at the time of the observation, the US FOIA (b)(6) confirmed that an audible signal was not activated when he applied force to the release device in the Activity Room. He stated he checks the delayed egress doors once a month and he did check the door last month.	K 222	1. What correction action(s) will be accomplished for those residents affected by the deficient practice? The 15-second delayed egress locking system for the exit door located in the Activity Room adjacent to Therapy, did not activate an audible signal when the Vice President of Plant Operations applied force to the release device. The Maintenance Director adjusted the egress plunger which corrected 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 had the potential to be affected by the deficient practice. The egress plunger was adjusted immediately which activated the alarm on the 15 second delayed egress locking system.	

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K 222	Continued From page 3 NJAC 8:39-31.1(c), 31.2(e)	K 222	3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The maintenance department was educated that all 15 second delay egress locking systems must active an audible signal when force is applied. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? All 15 second delay egress locking systems will be audited weekly to ensure an audible signal activates when force is applied. this audit will be ongoing weekly. All Findings will be reported through the Quality Assurance Committee at Quarterly Meeting x4.	
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 observations and interview, the facility failed to ensure means of egress were provided with the required automatic illumination in the event of any interruption of normal lighting in	K 281	K281 Illumination of Means of Egress 1. What correction action(s) will be accomplished for those residents affected	3/17/25

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K 281	Continued From page 4 accordance with NFPA 101 (Life Safety Code, 2012 Edition) Chapters 19.2.8 and 7.8. This deficient practice had the potential to affect 55 residents. Findings include: An observation on 01/30/25 at 2:48 PM of the emergency light fixture located at the exit adjacent to the front gym revealed the fixture only had one single bulb emergency lighting fixture. An observation on 01/30/25 at 2:51 PM of the emergency light fixture located at the exit located adjacent to the back gym revealed the fixture only had one single bulb emergency lighting fixture. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the exits had only a single bulb emergency lighting fixture. He stated these exits were not used as exits for the residents and did not need two bulbs. NJAC 8:39-31.2(e)	K 281	by the deficient practice? The single bulb emergency lighting fixture located at the exit adjacent to the front gym and located adjacent to the back gym was replaced to double light bulb fixtures. The double light bulb fixtures were installed 2/27/25 at the front and back gym. (color photos sent via email for verification work was complete.) 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 had the potential to be affected by the deficient practice. The single light bulb fixture located at the exit adjacent to the front gym and located adjacent to the back gym will be replaced to double light bulb fixtures. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The double light bulb fixtures will be audited for proper functionality weekly x 4, then monthly x2. All Findings will be reported to the Quality Assurance Committee Meetings. 4. How the corrective actions 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 5	K 281	The double light bulb fixtures will be audited for proper functionality weekly x 4, then monthly x2. All Findings will be reported to the Quarterly Quality Assurance Committee Meeting x1.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure hazardous areas were maintained free of unsealed openings to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code 2012 Edition) 19.3.2. This deficient practice had the potential to affect nine residents. Findings include: Observations on 01/30/25 at 2:53 PM of the electrical closet located adjacent to Room 109 revealed the room had a bundle of flexible conduit penetrating a ¾-inch unsealed opening and a bundle of flexible conduit penetrating a	K 311	K311- Vertical Openings Enclosure 1. What correction action(s) will be accomplished for those residents affected by the deficient practice? The electrical closet located adjacent to Room 109 revealed the room had a bundle of flexible conduit penetrating a -inch unsealed opening and a bundle of flexible conduit penetrating a 1-inch diameter unsealed opening above the electrical panels. The penetration was sealed with fire grade sealer immediately.	3/17/25

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K 311	Continued From page 6 1-inch diameter unsealed opening above the electrical panels. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the unsealed penetrations in the electrical closet. NJAC 8:39-31.2(e)	K 311	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 had the potential to be affected by the deficient practice. The electrical closet located adjacent to Room 109 revealed the room had a bundle of flexible conduit penetrating a -inch unsealed opening and a bundle of flexible conduit penetrating a 1-inch diameter unsealed opening above the electrical panels. The penetration was sealed with fire grade sealer immediately. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The Maintenance Department was educated that there cannot be any penetrations around the bundle of flexible conduits. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The electrical closet located adjacent to Room will be audited weekly x4 then monthly x2 to ensure no open penetration. All Findings will be reported through the Quarterly Quality Assurance Committee x1.	

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K 345	Continued From page 7	K 345		
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 observations and interview, the facility failed to ensure the dedicated branch circuit supplying the fire alarm equipment was permanently identified at the fire alarm control unit and the circuit disconnecting means for the fire alarm equipment had red identification and was identified as "FIRE ALARM CIRCUIT." In addition, the facility failed to ensure the dedicated branch circuit was accessible only to authorized personnel and protected against physical damage in accordance with NFPA 72 (National Fire Alarm Code 2010 Edition) Chapter 10.5.5.3. This deficient practice had the potential to affect all 118 residents. Findings include: Observations on 01/30/25 at 1:42 PM revealed the dedicated branch circuit was not identified at the fire alarm control unit. Continued observation revealed the dedicated branch circuit was not identified in red as "FIRE ALARM CIRCUIT" and the dedicated branch circuit was not protected against unauthorized personnel and physical damage.	K 345	K345- Fire Alarm Testing- Testing and Maintenance 1. What correction action(s) will be accomplished for those residents affected by the deficient practice? The dedicated branch circuit was not identified at the fire alarm control unit. The dedicated branch circuit was not identified in red as "FIRE ALARM CIRCUIT" and the dedicated branch circuit was not protected against unauthorized personnel and physical damage. Identification markers were placed, and a circuit lockout was installed. 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 had the potential to be affected by the deficient practice. Identification markers were placed, and a	3/17/25

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K 345	Continued From page 8 During an interview at the time of the observations, the US FOIA (b)(6) confirmed the dedicated branch circuit was not identified at the fire alarm control and the dedicated branch circuit did not have the required identification. The US FOIA (b)(6) also confirmed the dedicated branch circuit was not protected against unauthorized personnel and physical damage. He stated he did not know there was a requirement regarding the circuit. NJAC 8:39-31.2(e) NFPA 72	K 345	circuit lockout was installed. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The Maintenance Department was educated that Identification markers and a circuit lockout must be in place at the fire alarm control unit. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The fire alarm control unit will be audited weekly x 4, then monthly x2 for identification markers and circuit lockout. All Findings will be reported to the Quarterly Quality Assurance Committee Meetings x1.	
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 maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		3/17/25

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K 353	Continued From page 9 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 document review and interview, the facility failed to ensure the deficiencies or impairments found during the inspection, testing, and maintenance of the Sprinkler Systems were corrected or repaired in accordance with NFPA 25 (Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection 2011 Edition) Chapter 4.1.4.1. This deficient practice had the potential to affect all 118 residents. Findings include: A review of the facility's "Water Based Fire Protection Inspection & Test Report, dated 01/22/24 of the Sprinkler Systems revealed deficiencies noted on inspections conducted on 01/22/24 and 01/17/25 revealed no documented evidence to indicate the deficiencies had been corrected. The deficiencies noted on 01/22/24 indicated: "2-General ...F. Has the Fire Dept Connection piping been hydrostatically tested in the last 5 years? Year Due: Now" The deficiencies noted on 01/17/25 indicated:	K 353	K353 Sprinkler System □ Maintenance and Testing 1. What correction action(s) will be accomplished for those residents affected by the deficient practice? The Fire Dept Connection piping will be hydrostatically tested now and every 5 years. The supervisory electrical switch issue was fixed immediately. 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 had the potential to be affected by the deficient practice. The Fire Dept Connection piping will be hydrostatically tested now and every 5 years. The supervisory electrical switch issue was fixed immediately. (The evidence for the completion of the hydrostatic test was sent via email.) 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not	

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K 353	Continued From page 10 "3-Control Valves ...A. Did all electrical supervisory switches actuate supervisor alarms? No" During an interview on 12/30/25 at 12:30 PM, the US FOIA (b)(6) stated he did not realize there were deficiencies that needed to be corrected. He stated when he first arrived at the facility he could not locate the inspection binder and did not know what needed to be completed. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	recur? The Maintenance Department was educated that the Fire Dept Connection piping must be hydrostatically tested now and every 5 years and that the supervisory electrical switch must be functioning properly and safely. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The Fire Dept Connection piping hydrostatic test will be audited weekly until complete for this year, then yearly x 6 years. The supervisory electrical switch will be audited weekly x4, then monthly x2 to ensure it is functioning properly and safely. All Findings will be reported to the Quarterly Quality Assurance Committee Meetings x1, then yearly x 6.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	K 911	K911 Electrical Systems- other	3/17/25

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K 911	Continued From page 11 failed to ensure an electrical junction box was provided with a cover compatible with the box and suitable for the condition of use in accordance with NFPA 70 (National Electrical Code 2011 Edition) Article 314.28(C). This deficient practice had the potential to affect 18 residents. Findings include: An observation on 01/30/25 at 1:32 PM revealed an open electrical junction box, located above the smoke barriers doors and adjacent to Room 115, contained wiring for a light fixture and did not have a cover. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the junction box did not have a cover. NJAC 8:39-31.2(e) NFPA 70	K 911	1. What correction action(s) will be accomplished for those residents affected by the deficient practice? The open electrical junction box, located above the smoke barriers doors and adjacent to Room 115, contained wiring for a light fixture and did not have a cover. The cover was immediately installed. 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 had the potential to be affected by the deficient practice. A cover was installed on the open electrical junction box, located above the smoke barriers doors and adjacent to Room 115. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? The open electrical junction box, located above the smoke barriers doors and adjacent to Room 115 will be audited for a proper cover weekly x 4, then monthly x2. All Findings will be reported to the Quality Assurance Committee Meetings. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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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
K 911	Continued From page 12	K 911	program will be put into place? The open electrical junction box, located above the smoke barriers doors and adjacent to Room 115 will be audited for a proper cover weekly x 4, then monthly x2. All Findings will be reported to the Quality Assurance Committee Monthly x3.	
K 917 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Receptacles Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. 6.4.2.2.6, 6.5.2.2.4.2, 6.6.2.2.3.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure electrical receptacles supplied from the critical branch had a distinctive color or a cover plate with a distinctive color or marking in accordance with NFPA 99 (Health Care Facilities Code 2012 Edition) Chapter 6.6.2.2.3.2. This deficient practice had the potential to affect all 118 residents. Findings include: An observation on 01/30/25 at 2:12 PM revealed the medication refrigerator, located at the nurses' station on the Second Floor First Hall was plugged into a standard electrical receptacle, and did not have an electrical receptacle or cover plate with a distinctive color or marking. An observation on 01/30/25 at 2:39 PM revealed	K 917	K917 Electric Systems- Essential Electric Systems 1. What correction action(s) will be accomplished for those residents affected by the deficient practice? The medication refrigerator, located at the nurses' station on the First and Second Floor First Hall, was plugged into a standard electrical receptacle, and did not have an electrical receptacle or cover plate with a distinctive color or marking. Both Refrigerators were placed on an emergency circuit receptacle. The emergency circuit receptacle was professionally wired into our emergency circuit breaker box. 2. How will you identify other residents	3/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING **01** B. WING _____	**01/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	**6818 DELILAH ROAD** **EGG HARBOR TOWNSHIP, NJ 08234**

(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 917	Continued From page 13 the medication refrigerator located on the First Floor Medication Prep Room was plugged into a standard electrical receptacle, and did not have an electrical receptacle or cover plate with a distinctive color or marking. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the medication refrigerators were plugged into a regular outlet. He further stated he did not know if the refrigerators were connected to emergency power. NJAC 8:39-31.2(e)	K 917	having the potential to be affected by the same deficient practice and what corrective action will be taken? All residents had the potential to be affected by the deficient practice. Both Medication Refrigerators were placed on an emergency circuit receptacle. 3. What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur? Both Medication Refrigerators will be audited weekly x4 then Monthly x2 to ensure they are plugged into the emergency circuit receptacle. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Both Medication Refrigerators will be audited weekly x4 then Monthly x2 to ensure they are plugged into the RED emergency circuit receptacle. all emergency outlets have a red cover. Findings will be reported to QAPI monthly x3.	

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
315514 Y1	A. Building 01 - EGG HARBOR HCC B. Wing Y2	3/31/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT EGG HARBOR	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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 K0222	03/07/2025	LSC K0281	03/17/2025	LSC K0311	03/17/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	03/17/2025	LSC K0353	03/17/2025	LSC K0911	03/17/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0917	03/17/2025	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 1/31/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO