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 08/21/2021

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 Complaint #: NJ146046; NJ145548 and NJ145439 Census: 65 Sample Size: 9 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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	F 609		9/17/21

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

Electronically Signed | 09/15/2021

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F 609	Continued From page 1 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ146046 Based on record review and interview, it was determined the facility failed to ensure it called in a reportable to the State Survey Agency (SSA). Specifically, the facility failed to ensure it reported an injury of unknown origin to the SSA for 1 (Resident #3) of 4 residents reviewed for falls/injury. Findings included: 1. Resident #3 was readmitted on NJAC 8:43E-2.1 and Exec O with diagnoses including NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted] he 02/06/2021 quarterly Minimum Data Set (MDS) revealed the resident was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. NJAC 8:43E-2.1 and E with a Brief Interview for Mental Status score of NJAC 8:43E-2.1 and Exec Ord. The resident required two-persons physical assistance with transfer. The resident required one-person physical assistance with bed mobility, locomotion, dressing, toilet use, and personal hygiene. The resident required assistance with setup to eat. A review of the progress note dated 05/05/2021 revealed a note charted by Nurse	F 609	1. How the corrective action will be accomplished for those residents to have been affected by the deficient practice: It was found and determined that there was a deficient practice for resident #3. The deficient practice was rectified in that the DON notified the State Survey Agency (SSA) of the initial fall with unknown origin. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected by the deficient practice . 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: There has been a new DON since the date of the non-reported incident. The current DON or designee is monitoring all incident reports daily to ensure all required reportables are called to the State Survey Agency (SSA) in the required timeframe.	

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F 609	Continued From page 2 Supervisor/Registered Nurse (RN) #1. The note read that at 4:45 AM, RN #1 was notified by Licensed Practical Nurse (LPN) #2 that Resident #3 [NJAC 8:43E-2.1 and Exec] RN #1 noted that upon entering the room, Resident #3 was seen [NJAC 8:43E-2.1 and Exec Order 26, 4. b] and on the resident's [NJAC 8:43E] . The resident's [NJAC 8:43E] was noted to be towards the [NJAC 8:43] of the resident's bed. It was indicated in the report that Resident #3 was unable to describe how they [NJAC 8:43E-2.1 and Exe]. The report indicated that Resident #3 complained of NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. . The record revealed the resident was assessed, and the facility received an order to send the resident to the emergency room. A review of the hospital record revealed Resident #3's admitting diagnosis at the hospital was a [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]. The incident report completed by the facility following Resident #3's [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.] indicated that Certified Nurse Aide (CNA) #3 last observed Resident #3 sleeping in bed at 3:00 AM. The record indicated that at [NJAC 8:43E-2.1 and], CNA #3 notified LPN #2 that Resident #3 was [NJAC 8:43E-2 NJAC 8:43E-2.1 and Exec Or]. The report indicated that the care plan related to Resident #3's [NJAC 8] was in place (half rails were up) at the time the resident was [NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.]. The record indicated the resident was assessed and noted with confusion. The record indicated that Resident #3 was unable to state how they fell. The record revealed the facility interviewed CNA #3 who clarified that she was not providing care with Resident #3 at the time she observed the resident [NJAC 8:43E-2.1 and Exec C]. Specifically, the incident report indicated that CNA #3 stated that she was conducting her two hourly rounds when she observed Resident #3 [NJAC 8:43E-2.1 and Exec C].	F 609	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will audit incident reports weekly x4, monthly x2 and report findings to Quality Assurance Committee. Plan of correction date is September 17th 2021.	

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F 609	Continued From page 3 On 08/21/2021 at 4:17 PM, the Director of Nursing (DON) said the facility immediately assessed Resident #3 when it was reported by CNA #3 that the resident was observed [NJAC 8:43E-2.1 and Exec Ord] [NJAC 8:43E]. She stated that although Resident #3 was observed [NJAC 8:43E-2.1 and Exec Ord] the resident's care plan related to [NJAC 8:43E] (half rails were up to aid the resident in bed mobility) was noted to be in place when the resident was [NJAC 8:43E-2.1] [NJAC 8:43E-2.1 and Exec Ord]. She said the facility's investigation did not corroborate that CNA #3 made Resident #3 [NJAC 8:43E-2.1 and Exec Ord]. The DON said the plan was to reassess the resident for [NJAC 8:] interventions once the resident returned from the hospital. She said Resident #3 did not return to the facility. The DON said the incident with Resident #3 was treated as a [NJAC 8:], so the facility did not report it as an injury of unknown origin to the New Jersey Department of Health (NJDOH). The DON acknowledged there was no witness to the incident, and Resident #3 was unable to verbalize what occurred. Therefore, the facility initiated an investigation as to how the incident occurred. She acknowledged that when the investigation began, it should have been reported to the State Survey Agency as an injury of unknown origin, even though after the investigation they determined it was from a [NJAC 8:] New Jersey Administrative Code 8:39-5.1(a)	F 609		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315514 Y1	Y2	9/17/2021 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(c)(1)(4) LSC	Correction Completed 09/17/2021	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/21/2021	