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 01/11/2021

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 # NJ00138097, NJ00139426 Census: 73 Sample size: 4 The facility is not in compliance with the requirements of 42 CFR Park 483, Subpart B, for Long Term Care Facilities on this complaint survey.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580		1/27/21

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

Electronically Signed | 01/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint #: NJ139426 Based on record review and interviews, the facility failed to notify the responsible party of a change in condition for one (Resident #2) of three residents reviewed for pressure ulcers. Findings included: 1. Resident #2 was admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses including [redacted], [redacted]. The resident [redacted] at the	F 580	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Based on record review and interviews the facility failed to notify the responsible party of a change in condition for one(Resident #2) of three residents reviewed for [redacted]. Patient is no longer in Egg Harbor Care Center. An audit of all residents with pressure ulcers was conducted to identify any residents in need of change in condition notification. Family notification completed.	

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	315514	A. BUILDING _____ B. WING _____	C 01/11/2021

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 580	Continued From page 2 facility on [redacted]. A review of the most recent annual Minimum Data Set (MDS), dated [redacted] revealed Resident #2 was [redacted] with a Brief Interview for Mental Status score of [redacted]. A review of the updated care plan of 08/05/2020, revealed Resident #2 was at risk for [redacted] related to [redacted]. Resident #2's skin was intact on [redacted]. Interventions in place included in part, a pressure relieving mattress, adequate nutrition and hydration, and a [redacted] cushion to the wheelchair. A review of the nursing note dated 04/27/2020, revealed the resident had an [redacted]. Treatment was applied to the site. The note did not indicate the responsible party was notified. A review of the nursing note dated 07/12/2020, revealed the resident was noted to have an open area on the [redacted], which measured [redacted]. The physician was made aware and a new order for [redacted] to be applied to area daily was given. The note did not indicate the responsible party was notified. A review of the physician's order dated 08/06/2020 revealed an order for an air mattress and the [redacted] was healed and orders were written to discontinue the [redacted] to the [redacted]. A new order was written for [redacted] to be applied to the [redacted].	F 580	2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. 3. what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Don/designee provided retraining to all nursing staff regarding family notification on change of condition. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Don/designee will conduct weekly audits of patient pressure ulcers to ensure family notification on change of condition was completed. This audit will continue for 3 months or until compliance is achieved. Monthly report of this process will be provided to administration and a quarterly report will be reported to quality assurance performance improvement committee for one year.	

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	315514	A. BUILDING _____ B. WING _____	C 01/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 3 A review of the nursing note dated 08/06/2020, revealed the treatment to the [redacted] was discontinued. There was a new order for [redacted] to be [redacted] and as needed and an order for an air mattress. The note did not indicate the responsible party was notified of a new treatment to the[redacted]. During an interview with the Director of Nursing (DON) on 01/11/2021 at 1:58 PM, she stated that the responsible party should have been notified of changes in the resident's skin and treatments. New Jersey Administrative Code § 8:39-5.1(a)	F 580		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315514	A. Building B. Wing	1/29/2021

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 F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 01/27/2021	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 1/11/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			