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 04/03/2023

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 Complaint # NJ00150227, NJ00152333, NJ00152627, NJ00153588, NJ00154954 Census: 106 Sample Size: 28 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 582 SS=B	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 (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	F 582		5/10/23

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

Electronically Signed | 04/19/2023

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F 582	Continued From page 1 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. 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 notice for 1 of 3 residents (Resident #193) reviewed for the Beneficiary Protection Notification. This deficient practice was evidenced by the following:	F 582	F582: SS=B Medicare Coverage/Liability Notice 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 notice for 1	

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F 582	Continued From page 2 On 03/22/2023 at 11:32 AM the surveyor requested (3) random residents, (1) of whom discharged to home (Resident #193) and (2) who remained in the facility to determine if the facility provided documentation of appropriate notifications On 3/24/2023, the surveyor reviewed the SNF (Skilled Nursing Facility) Beneficiary Protection Notification Review (SNFBPNR) completed by the facility for Resident # 193. The SNFBPNR indicated Resident # 193's last covered Medicare day was [redacted]. A further review of the SNFBPNR further revealed that the facility/provider initiated the discharge from Medicare Part A services when benefit days were not exhausted. The SNFBPNR indicated that a SNFABN form CMS-10055 was provided to the resident. The SNFBPNR also revealed that a Notice of Medicare Non-Coverage Form CMS-10123 (NOMNC) was not provided to Resident #193 upon discharge to home.. The section regarding the NOMNC included documentation that it was, "No, Not the correct paperwork" During an interview with the surveyor on 03/28/2023 at 08:50 AM, the facility Social Worker (SW), when asked who determines what forms are provided to residents discharged from Medicare A, she replied that for residents under Medicare part A it is determined between therapy, SS (social services) and nursing. The SW went on to say that I do the SNFABN for residents on Medicare A and we always give them, regardless. If it is a resident-initiated discharge, we do not give SNFABN. If facility initiated, we do give SNFABN, if we feel they	F 582	of 3 residents (Resident #193) reviewed for the Beneficiary Protection Notification. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Resident #193 is no longer in the facility as he/she was discharged home. Resident was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents who are being discharged from SNF (Skilled Nursing Facility) Medicare Part A Coverage have the potential to be affected by the same deficient practice. The Clinical Reimbursement Coordinator/Consultant reviewed all residents who were discharged from Medicare Part A services since March 21, 2023, to ensure that the Social Worker issued the appropriate Beneficiary Notice(s). No other residents were affected. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The Social Workers and other members of the UR (Utilization Review) Team were in-serviced on the regulations re: Beneficiary Protection Notification. Emphasis was made on promptly issuing the NOMNC (Notice Of Medicare	

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F 582	Continued From page 3 reached their goals and no longer require services. The surveyor then asked what about residents discharged to home? The SW responded that either they get Managed Care NOMNC or SNFABN. She further stated, "Yes, if a resident is discharged to home, they get a NOMNC and a SNFABN whether they stay in the facility or discharge to home." The surveyor requested the SW review the SNFBPNR, and she said yes, he/she got SNFABN and because he/she was not managed care he did not get NOMNC. When asked if Resident #193 should have received NOMNC, the SW replied, "Yes he/she should have received a NOMNC from the facility as well." NJAC 8:39-4.1(a)(7)	F 582	Non-Coverage) when a resident is being discharged from Medicare Part A services. ¿ The appropriate Beneficiary Notice(s) that need to be issued for Medicare Part A residents will be discussed and incorporated in the Weekly UR (Utilization Review) Meeting Form. IV. MONITORING OF CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: ¿ The Administrator or Designee will conduct Medical Record audits of 5 Discharged Medicare A beneficiaries per month x 6 months □ to ensure that the proper Beneficiary Notices are issued. Findings will be presented at the quarterly QAA Meeting. Committee will determine the need for further audits and/or action plans to ensure on-going compliance. V. COMPLETION DATE: May 10, 2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		5/10/23

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F 656	Continued From page 4 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to develop a	F 656	F 656 SS=D Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 5 comprehensive, person-centered care plan for 3 of 28 sampled Residents, (Resident # 189, Resident #48, and Resident #135). This deficient practice was evidenced by the following: 1.) During the initial tour of the facility on 03/21/2023 at 10:54 AM, Resident # 189 was observed in bed with [redacted] in use. Resident #189 said he/she does not use [redacted] at home and has only used since being hospitalized. A review of the Admission Face Sheet revealed Resident #189 was admitted to the facility with diagnoses including but not limited to: [redacted] A review of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care, dated [redacted] revealed under section C a Brief Interview for Mental Status score of [redacted] indicating Resident #189 had [redacted] Under section O the MDS indicated Resident #189 [redacted] while a resident. A review of the Physician Orders as of [redacted]) A review of Resident #189's Care Plan did not include the use of [redacted] On 03/27/2023 at 09:39 AM, the surveyor reviewed Resident #189's care plan again and there was no care plan for [redacted] use. During an interview with Surveyor #1 on	F 656	Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to develop a comprehensive, person-centered care plan for 3 of 28 sampled Residents, (Resident # 189 Resident #48, and Resident #135). I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Resident #189 is no longer in the facility as he/she was discharged home. Residents were not adversely affected by the deficient practice. The Care Plan of Resident #48 updated by the the Unit Manager to include Plan of care to address resident's EX. Order 26.(4) B1 EX. Order 26.(4) B1 . ¿ Resident #135 is no longer a resident as resident expired. II. 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 of not having comprehensive, person-centered care plans. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The Interdisciplinary Team members and Nursing Staff were in-serviced on the the RAI (Resident Assessment Instrument) Process, with focus on	

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F 656	Continued From page 6 03/29/2023 at 09:23 AM, Unit Manager/Registered Nurse (UM/RN #1) said the admitting nurse, Unit Manger and MDS coordinator are responsible for doing the care plans. UM/RN #1 went on to say she expects EX. Order 26.(4) B1 , ADL's (Activities of Daily Living), side rails, falls and if on antibiotic or has an EX. Order 26.(4) B1, and if on EX. Order 26.(4) B yes, there should be a care plan. UM/RN #1 further explained that the MDS coordinator is to add any special disease, such as if Diabetic and getting EX. Order 26.(4 it has to be on the care plan. UM/RN #1 confirmed that if a resident is EX. Order 26.(4) B1 the surveyor would expect to see a care plan. UM/RN #1 said that EX. Order 26.(4) B and EX. Order 26.(4) B1 are done upon admission by the admitting nurse and we put an EX. Order 26.(4) B order in and it goes on baseline care plan. UM/RN #1 explained that she goes through the admission chart the next day and I do the comprehensive care plan and then the MDS coordinator goes in and adds anticoagulant, EX. Order 26.(4) B1 and anything else that needs to be done. On 03/29/2023 at 09:29 AM, Surveyor #1 requested UM/RN #1 to look at Resident #189's care plan and tell the surveyor if [redacted] use is care planned. On 03/29/2023 at 09:31 AM, UM/RN #1 said, "No, Resident #189 doesn't a have care plan for [redacted] " UM/RN #1 replied, "Yes", when asked should he/she have a care plan for [redacted] use. During an interview with Surveyor #1 on 03/31/2023 at 01:27 PM, the Vice President of Clinical Services (VPCS) said we have the unit manger or MDS coordinator do the care plans.	F 656	developing a comprehensive, person-centered care plan for each resident, to meet each resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The MDS Coordinator(s) or Designee will conduct 5 Care Plan Audits weekly x 4 weeks, then 5 Care Plan Audits monthly x 3 months. Audits will focus on verifying the completion of a Comprehensive Person-centered Care Plan, to meet the resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. Results of audits will be reported to the Administrator monthly and presented in the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans for on-going compliance. V. COMPLETION DATE: May 10, 2023	

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F 656	Continued From page 7 We do the baseline care plan in 48 hours and comprehensive care plan as soon as possible, 72 hours to 7 days. When asked what is expected to be on a care plan, the VPCS replied, "A picture of the patient. If they have a [redacted], side rails[redacted], [redacted], [redacted]. 2.) On 03/29/2023 at 11:11 AM, during the initial tour of the facility, Surveyor #2 observed Resident #48 awake in bed. At this time, Resident #48 confirmed he/she used [redacted]). A review of Resident #48's MDS dated [redacted] located in the Electronic Medical Record (EMR) revealed he/she had a diagnosis of but not limited to [redacted]. The MDS further revealed that Resident #48 received [redacted]. A review of Resident #48's Physician's Orders revealed an order for [redacted] at bedtime. A review of Resident 48's Care Plans located in the EMR did not include a care plan for [redacted] On 03/28/2023 during an interview with Surveyor #2, UM/RN #1 confirmed that if a resident is [redacted] and receives [redacted] they should have a [redacted] care plan just to make sure they (facility) are monitoring what's going on. UM/RN #1 said, "To make sure we EX. Order 26.(4) B1 with [redacted] prior to administering [redacted]" when Surveyor #2 asked what interventions might be	F 656		

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F 656	Continued From page 8 included in the care plan. On 03/31/2023 at 01:13 PM, during an interview with Surveyor #2, the VPCS said residents should have a care plan if they are diagnosed with [redacted]. Further, the VPCS said that a care plan should be established within 72 hours. 3.) A review of Resident #135's closed record revealed that he/she passed away. A review of Resident #135's MDS dated 02/01/2023, located in the EMR, revealed he/she had a diagnosis of [redacted] (disease involving EX. Order 26.(4) B1). The MDS further revealed that Resident #135 received [redacted]. A review of Resident #135's Physician's Orders revealed orders for EX. Order 26.(4) B1 medication used to manage EX. Order 26.(4) B1 On 03/28/2023 at 01:00 PM, during an interview with Surveyor #2, UM/RN #1 confirmed that Resident #135 never had a care plan for [redacted]. On 03/31/2023 at 01:13 PM, during an interview with Surveyor #2, the VPCS said residents should have a care plan if they are diagnosed with [redacted]. Further, the VPCS said that the care plan should be established within 72 hours. A review of a facility policy titled Comprehensive Resident Centered Care Plans, dated [redacted] revealed that a person-centered care plan	F 656		

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F 656	Continued From page 9 includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. A further review of the policy indicated under "Procedure", that a person-centered care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. NJAC 8:39-11.2 (e)	F 656		
F 658 SS=E	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: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a) maintain professional standards of clinical practice by not following the physician's order for EX. Order 26.(4) B1 EX. Order 2 parameters for 1 of 28 sampled residents (Resident # 29) and b) follow professional standards of nursing practices and facility policy by not notifying the Licensed Independent Practitioner of a prescribed medication that was not administered as ordered for 1 of 2 residents during a medication pass observation. This deficient practice was evidenced by the following:	F 658	F 658: S/S =E Services Provided Meet Professional Standards Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a) maintain professional standards of clinical practice by not following the physician's order for blood EX. Order 26.(4) B1 parameters for 1 of 28 sampled residents (Resident # 29) and b) follow professional standards of nursing practices and facility policy by not notifying the Licensed Independent Practitioner of a prescribed medication that was not administered as ordered for	5/10/23

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F 658	Continued From page 10 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 response to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to 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 case finding; 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." There was no adverse effect on Resident #29. According to the facility Admission Face Sheet Resident #29 was admitted to the facility with diagnoses including but not limited to: [redacted] A review of the physician's orders revealed an order dated [redacted] for an [redacted] medication; "[redacted] Oral Tablet [redacted] MG tablet, 1 tablet by mouth [redacted] daily. Special	F 658	1 of 2 residents during a medication pass observation. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Physician was notified by the Director of Nursing regarding the failure of some nurses to follow [redacted] parameters in the administration of [redacted] for Resident #29 from [redacted] through [redacted]. MD subsequently discontinued the [redacted] parameters in the administration of [redacted] for Resident #29. Resident #29 was not adversely affected by the deficient practice. ¿ The Director of Nursing/Designee counseled the nurses who failed to follow the physician's order for [redacted] parameters in the administration of [redacted] for Resident #29. The nurses were in-serviced on the importance of following Physician□s Orders for [redacted] Parameters and notifying the Physician when a medication was not administered as ordered, ¿ LPN notified Physician of Resident #3 that [redacted] was not administered on 3/28/23 at 8:00 AM. No new orders given. LPN # 2 documented notification in the resident□s chart. LPN # 2 was re-educated on facility□s policy on what to do when a medication is not available during Medication Administration. Resident #3 was not adversely affected	

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

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F 658	Continued From page 11 Instructions: [redacted] Medical Conditions: [redacted] " On 03/27/2023 at 10:26 AM, Surveyor #1 reviewed the Consultant Pharmacist's Medication Regimen Reviews from the previous 6 months [redacted] when [redacted] was not held as per [redacted] parameter." On 03/29/23 at 12:35 PM, the surveyor reviewed the Electronic Medication Administration Record (e-MAR) that showed the time of medication administration as well as the [redacted] at time of administration. The following information was obtained: A review of the March 2023 e-MAR reflected that [redacted] was held (not administered) on the following dates and times: On 03/12/2023 at 12:00 PM the [redacted] On 03/14/2023 at 08:00 AM the [redacted]. On 03/20/2023 at 08:00 AM the [redacted] A review of the February 2023 e-MAR reflected that [redacted] was administered outside of the parameters ([redacted]) as follows: On 02/7/2023 at 08:00 AM the [redacted] On 02/15/2023 at 08:00 AM the [redacted] On 02/16/2023 at 08:00 AM the [redacted] On 02/20/2023 at 08:00 AM the [redacted] On 02/12/2023 at 12:00 PM the [redacted] On 02/13/2023 at 12:00 PM the [redacted]	F 658	by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents with MD Orders for medications, including residents on [redacted] with orders for [redacted] parameters, are at risk for the same deficient practice. Unit Managers and Nursing Supervisors reviewed the current Medication Administration Records (MARs) of active residents to ensure that no other residents were affected by the same deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All nurses were in-serviced on the need to maintain professional standards of clinical practice when following physician□s orders with parameters, and on following professional standards of nursing practices and facility policy when a medication is not available. Emphasis was made on the following: (a) Administration of Medications according to the Physician's Order, (b) Adhering to the acceptable standards of nursing practice related to following the physician's order in the administration of medications with [redacted] parameters. (c) Following facility□s Policy when a medication is unavailable during	

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F 658	Continued From page 12 On 02/15/2023 at 12:00 PM the [redacted] On 02/27/2023 at 12:00 PM the [redacted] On 02/1/2023 at 04:00 PM the [redacted] On 02/4/2023 at 04:00 PM the [redacted] On 02/12/2023 at 04:00 PM the [redacted] On 02/23/2023 at 04:00 PM the [redacted] On 02/25/2023 at 04:00 PM the [redacted] A review of the [redacted] e-MAR reflected that [redacted] was administered outside of the parameters [redacted]) as follows: On 01/5/2023 at 08:00 AM the [redacted] On 01/8/2023 at 08:00 AM the [redacted] On 01/16/2023 at 08:00 AM the [redacted] On 01/23/2023 at 08:00 AM the [redacted] On 01/2/2023 at 12:00 PM the [redacted] On 01/7/2023 at 12:00 PM the [redacted] On 01/28/2023 at 12:00 PM the [redacted] On 01/7/2023 at 04:00 PM the [redacted] On 01/28/2023 at 04:00 PM the [redacted] On 03/29/2023 at 08:41 AM, the surveyor interviewed the Interim Unit Manager (IUM) for the [redacted] unit. The IUM stated that the process for administering medications requires the nurse to first check the physician order and follow it as directed. If the medication has a parameter such as a [redacted]), the nurse must first check the residents current [redacted]. Options on the e-MAR then prompt the nurse to document the [redacted] and chose if the medication was administered or not given (held).	F 658	Medication Pass. (d) Notifying the Physician when medications are not administered as ordered. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Unit Managers or designee will review the Medication Administration Records (MARs) of 10 residents x 3 months, to check whether medications are administered in accordance with physician□s orders, including compliance with [redacted] parameters if ordered. If medications were not given to a resident, medical records will be reviewed to ensure that the physician was notified and that it is documented in accordance with facility□s policy. Findings will be reported to the Director of Nursing and Administrator monthly and will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plan. V. COMPLETION DATE: May 10, 2023	

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If the medication is administered, the nurse checks "administered." If the medication is held an option to click "not given" is checked. The e-MAR will either reflect a check indicating that the medications was administered or an X indicating that the medication was not given.

The surveyor then reviewed the Consultant Pharmacist's Medication Regimen Review for the month of February with the IUM. The report indicated that there were administration errors regarding the administration of [redacted] given outside of parameters. The report also stated that, the Assistant Director of Nursing (ADON) was notified. The IUM acknowledged that she was the previous ADON and that she remembered the report.

On 03/31/2023 at 01:18 PM, the surveyor interviewed the Vice President of Clinical Services (VPCS) in the presence of the survey team. The surveyor reviewed the findings of the medication [redacted] being administered outside of the parameters and the VPCS acknowledged the concern stating, "The resident could become [redacted]"

A review of the facility's Medication Administration Policy and Procedure dated 3/1/2023, did not include documentation regarding medication parameters.

NJAC 8:39-27.1(a)

According to the Admission Record Resident #3 was admitted to the facility with a diagnosis that included but not limited to [redacted]

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F 658	Continued From page 14 [redacted] On 03/28/23 at 08:04 AM, Surveyor #2 conducted a medication pass observation for Resident #3. Licensed Practical Nurse (LPN #2) searched the medication cart then stated," its not here," referring to [redacted] (gram) packet. LPN #2 proceeded to select the box indicating that the medication was not given. A review of Resident #3's Physician Order Form revealed an order for "[redacted] packet [redacted] (8:00 AM and 4:00 PM) Diagnosis Described: [redacted] with a start date of [redacted] EX. Order 26.(4) B1. A review of the Medication Administration Record (MAR) revealed that the 08:00 AM dose of [redacted] was not administered on [redacted] EX. Order 26.(4) B1 for the 8:00 AM dose. During an interview with Surveyor #2 on 03/30/2023 at 12:57 PM, Surveyor #2 asked LPN #1 what is your process when medications are not available in the medication cart during medication administration. LPN #1 replied, "call the doctor for medications that are not available, sometimes the doctor Ok's for one dose not to be given, sometimes the doctor will recommend an alternative while the medication is not here yet." During an interview with Surveyor #2 on 04/03/2023 at 11:27 AM, the IUM confirmed that the 08:00 AM dose of [redacted] was not administered on 03/28/2023. In addition, the IUM replied, "No" when asked was the doctor notified that the medication was not administered.	F 658		

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F 658	Continued From page 15 During an interview with Surveyor #2 on 03/31/2023 at 01:18 PM, Surveyor #2 asked when medications are not available at the designated time, what is your process. The VPCS stated the nurse should check the backup automated medication dispensing machine, and if it is not there they should call the physician, let the doctor know, and whatever orders the physician wants to give at that moment and call the pharmacy for a stat (rush) delivery. A review of a facility policy titled Medication administration- medication availability, dated 2/1/2023 revealed "Our facility shall administer medications as per physician's order and protocol. Procedure:...4. In the event a medication is not available during medication administration, the licensed professional will proceed to check medication availability in the back up medication box. If medication is not available in the facility, the licensed professional will call the primary physician for further instructions. The pharmacy will be informed immediately." NJAC 8:39-27.1(a) NJAC 8:39-29.2(d)	F 658		
F 689 SS=D	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	F 689		5/10/23

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F 689	Continued From page 16 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate a known and foreseeable accident hazard in the residents environment specifically by leaving an open lid garbage receptacle in the outside EX. Order 26.(4) B1 area. The deficient practice was identified in 1 of 1 outside EX. Order 26.(4) B1 areas and was evidenced by the following: On 03/31/2023 at 11:10 AM during an observation of the outside EX. Order 26.(4) B1 area, the surveyor observed multiple extinguished EX. Order 26.(4) B1 on the ground throughout the area. Further, the surveyor also observed a gray plastic garbage receptacle not fully covered by the lid. Within the garbage receptacle was a clear, plastic bag filled with combustible materials such as a paper cup. Also, within the garbage receptacle were extinguished EX. Order 26.(4) B1 floating in small amount of water. On 03/31/2023 at 01:13 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) said that plastic garbage receptacles should not be in the outside EX. Order 26.(4) B1 area. The LNHA also said that the outside EX. Order 26.(4) B1 area should be cleaned daily and that it is the responsibilities of the facility's porters. A review of the facility policy titled, "Resident EX. Order 26.(4) B1 " updated on 2/03/2023 did not specifically address maintaining the grounds of the EX. Order 26.(4) B1 area.	F 689	F689: S/S = D Accident Hazards/Supervision/Devices Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the residents environment specifically by leaving an open lid garbage receptacle in the outside EX. Order 26.(4) B1 area. The deficient practice was identified in 1 of 1 outside smoking areas I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The plastic garbage receptacle in the outside EX. Order 26.(4) B1 area was immediately removed. The porter cleaned the outside smoking area to ensure that there were no foreseeable accident hazards. No residents were adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents who smoke in the outside EX. Order 26.(4) B1 areas have the potential to be affected by the same deficient practice. The Director of Maintenance checked all of the EX. Order 26.(4) B1 areas to	

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F 689	Continued From page 17 NJAC:8:39-31.6(e)	F 689	ensure that they were clean and free of any foreseeable accident hazards. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ Porters were in-serviced to ensure that the outside [redacted] areas remain clean and free of any foreseeable accident hazards. ¿ Director of Maintenance or designee will include observation of the outside [redacted] areas to ensure safety and cleanliness when conducting daily environmental rounds. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Administrator or Designee will conduct Observation Rounds of all [redacted] areas weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that the outside [redacted] areas remain clean and free of any foreseeable accident hazards. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. V. COMPLETION DATE: May 10, 2023	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that	F 690		5/10/23

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F 690	Continued From page 18 resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to maintain resident dignity when the [redacted]	F 690	5) F690 SS=D Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, review	

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F 690	Continued From page 19 EX. Order 26.(4) B1 bag was visible from the hallway and in the unit dining room for 1 of 2 Residents reviewed for EX. Order 26.(4) B1 EX. Order 26.(4) B1 (Resident # 87). This deficient practice was evidenced by the following: On 03/22/2023 at 09:38 AM, the surveyor observed Resident #87 in the unit dining room with his/her EX. Order 26.(4) B. The EX. Order 26.(4) B1 bag (attaches directly to the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 produced during the day and becomes EX. Order 26.(4) B) was observed to hanging next to the resident's EX. Order under the wheelchair, not attached to Resident #87's and below the . was exposed, and was visible from the hallway and in the dining room. A review of the Admission Face Sheet revealed Resident #87 was admitted to the facility with diagnoses including but not limited to: A review of the Minimum Data Set (MDS), an assessment tool used to facilitate care, dated EX. Order 26.(4) B1 revealed Resident #87 had EX. Order 26.(4) B1 cognition. The MDS further revealed Resident #87 had an . A review of the Physician Order sheet for Resident # 87 included an order for a every shift. A review of the Care Plan revealed under Indicator with an implemented date of	F 690	of the medical record and review of other facility documentation, it was determined that the facility failed to maintain resident dignity when the EX. Order 26.(4) B1 bag was visible from the hallway and in the unit dining room for 1 of 2 Residents reviewed for EX. Order 26.(4) B1 (Resident # 87). I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Upon identification of the deficient practice, the urine catheter drainage bag of Resident #87 was covered with a EX. Order 26.(4) B1 bag by the Unit Manager. Certified nursing assistant who was assigned to Resident #87 was counseled and in-serviced on ensuring that EX. Order 26.(4) EX. Order 26.(4) B1 bag is covered with a EX. Order 26.(4) B EX. Order to maintain resident's dignity. Resident #87 was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents with indwelling catheter have the potential to be affected by the same deficient practice. Director of Nursing and Assistant Director of Nursing checked all residents with EX. Order 26.(4) B1 EX. Order 26.(4) B1 to make sure that no other residents were affected by the same deficient practice.	

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F 690	Continued From page 20 EX. Order 26.(4) B1, new use of [redacted]. Under the Goal section, Resident will not have EX. Order 26.(4) B1 x90 days, Resident will not develop EX. Order 26. 90 days Interventions, all dated EX. Order 26.(4) B1 included but not limited to. Change [redacted] weekly 10PM-6AM on Thursday EX. Order 26.(4) B1EX. Order 26.(4) B1 not touching the floor Foley care q (every) shift and PRN (as needed) monitor [redacted] for EX. Order 26.(4) B1 consistency and amount no EX. Order 26.(4) B1. During an interview with the surveyor on 03/22/2023 at 11:47 AM, Unit Manager/Registered Nurse (UM/RN#1) said when using a [redacted], we put [redacted] on them (residents), so the EX. Order [redacted] is not seen and we check every 2 hours make sure it is attached, covered, and not exposed. The surveyor showed the UM/RN #1 the evidence of the [redacted] hanging, exposed, and not attached to Resident #87's [redacted]. UM/RN #1 replied, "It is not supposed to be that way and should be attached to his/her EX. Ord [redacted] at all times." During an interview with the surveyor on 03/28/2023 at 11:14 AM, the facility Director of Nursing (DON) told the surveyor. "My expectation is that residents with a [redacted] should always have the EX. Order [redacted] covered no matter where they are, and it should be off the floor. It is dignity." The Vice President of Clinical Services agreed and said it [redacted])	F 690	III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ Nursing Staff were educated on proper care of residents with EX. Order 26.(4) B1 [redacted] with emphasis on making sure that EX. Order 26.(4) B1 [redacted] bags are covered to maintain residents' dignity. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Assistant Director of Nursing or designee will conduct observation audits on 3 residents with EX. Order 26.(4) B1 weekly x 3 months. Focus of audit will be on ensuring that EX. Order 26.(4) B1 EX. Or Orde [redacted] are covered to maintain residents' dignity. Audit Findings will be submitted to the Director of Nursing Administrator monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans. V. COMPLETION DATE: May 10, 2023	

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	315514	A. BUILDING _____ B. WING _____	C 04/03/2023

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 690	Continued From page 21 was inappropriate to be that way when told that the [redacted] was observed hanging next to the [redacted] visible with [redacted] exposed while resident #87 was in the wheelchair visiting with his/her [redacted] in the unit dining room. A review of a facility policy titled Infection Control-EX. Order 26.(4) B1 Use, dated 3/01/2023, revealed under Procedure section 5: EX. Order 26.(4) B1 will be covered and maintained in a [redacted].	F 690		
F 755 SS=D	NJAC: 8.39-27.1(a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all	F 755		5/10/23

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F 755	Continued From page 22 aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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 ensure that the incoming and outgoing nurses reconciled controlled substances at change of shift. This deficient practice was identified for 2 of 2 medication carts on 2 of 2 nursing units. The deficient practice was evidenced by the following: On 03/27/23 at 08:52 AM, the Surveyor reviewed the narcotic log book on the [redacted] floor nursing unit [redacted] medication cart. A review of the Controlled Substance Inventory log for the EX. Order 26.(4) B1 medication cart for the month of March revealed that the signature of the incoming nurse and/or signature of outgoing nurse was blank on the following days/times: 03/08/2023 10 PM Outgoing nurse 03/18/2023 10 PM Outgoing nurse 03/19/2023 6 AM Incoming nurse 03/19/2023 10 PM Outgoing nurse	F 755	F 755: SS=D Pharmacy Services / procedures / Pharmacist / Records Based on interview and review of other facility documentation, it was determined that the facility failed to ensure that the incoming and outgoing nurses reconciled controlled substances at change of shift. This deficient practice was identified for 2 of 2 medication carts on 2 of 2 nursing units. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ No residents were adversely affected by the deficient practice. All nurses were educated re: the need to reconcile controlled substances at change of shift to ensure accountability of controlled substances. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT	

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F 755	Continued From page 23 03/26/2023 3-11 PM Incoming nurse 03/26/2023 3- 11 PM outgoing nurse 03/26/2023 11- 7 PM Outgoing nurse A review of the Controlled Medication Account Record for the EX. Order 26.(4) B1 medication cart revealed that multiple sections were left blank on the dates/shifts as follows: Total Count of items (Bingo Cards, bottles, boxes) 03/25/2023 7-3 PM, 3-11 PM, 11-7 AM shifts 03/26/2023 7-3 PM and 3-11 PM shifts 03/27/2023 7-3 PM shift # (Number) of new items received during this shift 03/25/2023 3-11 PM shift 03/26/2023 7-3 PM, 3-11 PM, 11-7 AM shifts Total # of declining sheets present 03/25/2023 03/26/2023 03/27/2023 On 03/29/2023 at 09:39 AM, the surveyor reviewed the narcotic log book on the EX. Order 26.(4) B1 EX. Order 26.(4) B1 Cart. A review of the Controlled Medication Account Record for March revealed that the signature of the incoming nurse and/or signature of the outgoing nurse was blank on the following days: 03/01/2023 7-3 PM Outgoing nurse 03/09/2023 7-3 PM Outgoing nurse 03/12/2023 3-11 PM Outgoing nurse 03/15/2023 7-3 PM Outgoing nurse	F 755	PRACTICE ¿ All residents have the potential to be affected by the same deficient practice. All the narcotic boxes in the medication carts were checked to identify any discrepancies between the narcotic medication inventory and the declining inventory sheets. No discrepancies were identified, and no residents were affected by the deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All licensed nurses were educated on the importance of proper documentation, i.e., the need to reconcile controlled substances at change of shift to maintain accurate accountability and reconciliation for controlled medications in the facility. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Unit Managers or designee will conduct audits of the Controlled Substance Reconciliation Records in all units on a weekly basis x 4 weeks, then monthly thereafter x 2 months. Focus of the audits will be on ensuring that incoming and outgoing shift nurses are reconciling controlled substances at change of shift. Audit Findings will be reported to the Director of Nursing monthly and presented in the quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance	

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F 755	Continued From page 24 03/28/2023 3-11 PM Incoming nurse 03/28/2023 11-7 AM Incoming nurse 03/28/2023 11-7 AM Outgoing nurse A review of the Controlled Medication Account Record for the EX. Order 26.(4) B1 Cart revealed that multiple sections were left blank on the dates/shifts as follows: Total Count of items (Bingo Cards, bottles, boxes) 03/01/2023 3-11 PM 03/04/2023 3-11 PM 03/10/2023 3-11 PM 03/16/2023 7-3 PM 03/18/2023 11-7 AM 03/19/2023 All 3 shifts 03/20/2023 All 3 shifts 03/21/2023 All 3 shifts 03/22/2023 7-3 PM 03/25/2023 11-7 AM 03/26/2023 11-7 AM 03/27/2023 All 3 shifts 03/28/2023 7-3 PM and 11-7 AM # (Number) of new items received during this shift 03/01/2023 11-7 AM 03/03/2023 3-11 PM - 3/6/23 11- 7 AM shifts 03/07/2023 11-7 AM 03/08/2023 7-3 PM, 3/8/23 3-11 PM 03/10/2023 3-11 PM, 11-7 AM 03/11/2023 7-3 PM, 3-11 PM, 11-7 AM 03/12/2023 3-11 PM 03/13/2023 7-3 PM, 3-11 PM, 11-7 AM 03/14/2023 7-3 PM, 3-11 PM, 11-7 AM 03/15/2023 7-3 PM, 11- 7 AM 03/16/2023 7-3 PM, 3-11 PM, 11-7 AM	F 755	Improvement) Committee will determine the need for further audits and/or action plans. V. COMPLETION DATE: May 10, 2023	

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F 755	Continued From page 25 03/18/2023 11-7 AM 03/19/2023 7-3 PM, 3-11 PM, 11-7 AM 03/20/2023 7-3 PM, 3-11 PM, 11-7 AM 03/21/2023 7-3 PM, 3-11 PM, 11-7 AM 03/22/2023 7-3 PM, 3-11 PM, 11-7 AM 03/23/2023 3-11 PM, 11-7 AM 03/24/2023 7-3 PM 03/25/2023 3-11 PM, 11-7 AM 03/26/2023 7-3 PM, 3-11 PM, 11-7 AM 03/27/2023 7-3 PM, 3-11 PM, 11-7 AM 03/28/2023 7-3 PM, 11-7 AM 03/29/2023 7-3 PM Total # of declining sheets present 03/01/2023 All shifts 03/02/2023 7-3 PM 03/03/2023 3-11 PM, 11- 7 AM 03/04/2023 All shifts 03/05/2023 All shifts 03/06/2023 All shifts 03/07/2023 7-3 PM 03/08/2023 All shifts 03/09/2023 All shifts 03/13/2023 All shifts 03/14/2023 All shifts 03/15/2023 All shifts 03/16/2023 All shifts 03/19/2023 All shifts 03/20/2023 All shifts 03/26/2023 All shifts 03/27/2023 All shifts 03/28/2023 All shifts During an interview with the Surveyor on 03/30/2023 at 12:54 PM, when asked what is the process when counting the narcotics at shift change, Licensed Practical Nurse (LPN #1) stated we count the bingo cards, both the	F 755		

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F 755	Continued From page 26 incoming and outgoing nurses sign. During an interview with the Surveyor on 03/31/2023 at 01:18 PM, when asked what is the process for shift change narcotic count, the Vice President of Clinical Services (VPCS) stated, "The incoming and outgoing nurse sign off and make sure the count is correct." The VPCS was asked what the expectation was of the incoming and outgoing nurses and the shift change narcotic count. The VPCS stated that each section on the Controlled Medication Account Record should be completed. The facility was unable to provide a facility policy and procedure regarding the narcotic count. NJAC 8:39-29.4 (k)	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist	F 756		5/10/23

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 756	Continued From page 27 during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility a)failed to ensure that the Consultant Pharmacist (CP) reported irregularities of drug regimen to the physician, and b.) failed to act upon the CP report of irregularities found while reviewing the drug regimen. This deficient practice was identified for 1 of 28 sampled residents, (Resident #29) and was evidenced by the following: There was no adverse effects to Resident #29. According to the Admission Face Sheet Resident #29 was admitted with diagnoses including but	F 756	F756: SS = E Drug Regimen Review, Report Irregular, Act On Based on interview, record review, and review of other facility documentation, it was determined that the facility a) failed to ensure that the Consultant Pharmacist (CP) reported irregularities of drug regimen to the physician, and b.) failed to act upon the CP report of irregularities found while reviewing the drug regimen. This deficient practice was identified for 1 of 28 sampled residents, (Resident #29) I. CORRECTIVE ACTION S	

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F 756	Continued From page 28 not limited to: [redacted]. According to the [redacted] Physician Order Sheet, resident #29 had an order dated [redacted] for an EX. Order 26.(4) B1 medication; EX. Order 26.(4) B1 Oral Tablet [redacted] MG (milligram) tablet, 1 tablet by mouth [redacted] times daily with "Special Instructions," (parameter) to hold the medication when the [redacted] On 03/27/2023 at 10:26 AM, the surveyor reviewed the Consultant Pharmacist's Medication Regimen Reviews (CPMRR) for the months of January 2023 through March 2023. For the month of January 2023, the Consultant Pharmacist did not identify or report [redacted] as being administered outside of parameters. A review of the February 2023 the Consultant Pharmacist reported; EX. Order 26.(4) B1 ordered to be held if EX. Order 26.(4) B1 greater than [redacted]-on 2/1/23 at 4 pm, on 2/4/23 at 4 pm and on 2/7/23 at 8 AM EX. Order 26.(4) B1 was greater than [redacted] but EX. Order 26.(4) B1 was signed as administered. [nurses name] ADON was notified." The CPMRR created in March reported, [redacted] Multiple instances noted when medication was not held, 2/12 8 am and 12 noon; 2/13 12 pm; 2/15 8 am and noon; 2/16 8 am; 2/20 8 am; 2/23 4 pm; 2/25 4 pm; 2/28 8 am-[nurses name], DON was notified."	F 756	ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Director of Nursing notified Resident #29□s attending physician regarding the failure of some nurses to follow the EX. Order 26.(4) B1 parameters in the administration of [redacted] for Resident #29 from January 2023 through March 2023. ¿ The Pharmacy Consultant was in-serviced by his/her supervisor re: ensuring that he/she reports drug regimen irregularities to the physician. Focus was made on checking for compliance with [redacted] ([redacted]) parameters in the administration of [redacted], if ordered by physician. ¿ The Unit Manager who failed to act upon Consultant Pharmacist□s recommendations for Resident #29 was counseled and re-educated by the Director of Nursing. Resident #29 was not adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents on [redacted] with orders for EX. Order 26.(4) B1) parameters are at risk for the same deficient practice. Unit Managers and Nursing Supervisors reviewed the current Medication Administration Records (MARs) of active residents on [redacted] to ensure that no other residents were	

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F 756	Continued From page 29 On 03/29/2023 at 12:35 PM, the surveyor reviewed the January 2023, February 2023, and March 2023 Electronic Medical Record (EMR's) that included the Medication Administration Records (e-MAR's) which revealed the nurses administered the medication [redacted] to Resident #29 when the [redacted] was above [redacted] 22 times and held EX. Order 26.(4) B1 MG, 3 times when the [redacted] was less than [redacted] as follows: A review of the March 2023 e-MAR reflected that [redacted] was held (not administered) on the following dates and times: On 03/12/23 at 12:00 PM the [redacted]. On 03/14/23 at 08:00 AM the [redacted]. On 03/20/23 at 08:00 AM the [redacted]. A review of the February 2023 e-MAR reflected that [redacted] was administered outside of the parameters EX. Order 26.(4) B1 greater than [redacted] On 02/7/2023 at 08:00 AM the [redacted] On 02/15/2023 at 08:00 AM the On 02/16/2023 at 08:00 AM the On 02/20/2023 at 08:00 AM the On 02/12/2023 at 12:00 PM the [redacted] On 02/13/2023 at 12:00 PM the On 02/15/2023 at 12:00 PM the On 02/27/2023 at 12:00 PM the On 02/1/2023 at 04:00 PM the [redacted] On 02/4/2023 at 04:00 PM the On 02/12/2023 at 04:00 PM the On 02/23/2023 at 04:00 PM the On 02/25/2023 at 04:00 PM the	F 756	affected by the same deficient practice. No additional residents were identified. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ Pharmacy Consultant and Nurses were in-serviced on the facility□s Policy on Drug Regimen Review, with emphasis on ensuring that drug regimen irregularities are reported to the physician and recommendations by the Pharmacy Consultant are acted upon. Focus was made on ensuring compliance with [redacted] EX. Order 26.(4) B1 parameters in the administration of [redacted] when ordered. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Director of Nursing or Designee will conduct Medical Review audits on 5 residents with orders for [redacted] EX. Order 26.(4) B1 [redacted] parameters in the administration of [redacted] This will be done monthly x 6 months to ensure that: (1) Drug regimen irregularities are reported by the Pharmacy Consultant to the Physician and, (2) Recommendations by the Pharmacy Consultant are acted upon by the Unit Managers promptly. Any identified issues will be rectified and addressed immediately. Audit Findings will be reported to the Administrator on a monthly basis and reported in the QAPI Meeting on a Quarterly Basis. The QAPI Committee will determine the need for	

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F 756	Continued From page 30 A review of the January 2023 e-MAR reflected that [redacted] was administered outside of the parameters [redacted] for [redacted] greater than [redacted] On 01/5/2023 at 08:00 AM the [redacted] On 01/8/2023 at 08:00 AM the [redacted] On 01/16/2023 at 08:00 AM the [redacted] On 01/23/2023 at 08:00 AM the [redacted] On 01/2/2023 at 12:00 PM the [redacted] On 01/7/2023 at 12:00 PM the [redacted] On 01/28/2023 at 12:00 PM the [redacted] On 01/7/2023 at 04:00 PM the [redacted] On 01/28/23 at 04:00 PM the [redacted] The facility was unable to provide documentation that the CPMRR regarding medication being given outside physician ordered parameters was addressed by the nursing staff. On 3/31/2023 at 1:18 PM, the surveyor interviewed the Vice President of Clinical Services (VPCS) in the presence of the survey team and the Licensed Nursing Home Administrator. The surveyor reviewed the findings of the medication [redacted] being administer outside of the parameters and the VPCS acknowledged concern stating, "The resident could become [redacted]." A review of a facility policy titled, "Pharmacy Services-Drug Regimen Review," dated 2/1/2023 included the following under #1. The drug regimen of each resident will be reviewed at least monthly by a licensed pharmacist and the pharmacist will report any irregularities to the attending physician, the facility's medical director	F 756	further audits and or action plans on a quarterly basis. COMPLETION DATE: May 10, 2023	

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	315514	A. BUILDING _____ B. WING _____	C 04/03/2023

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 756	Continued From page 31 and the director of nursing (DON). Under #4 and these reports will be acted upon. NJAC-8:39-29.3(a)	F 756		
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and review of other facility documents, it was determined that the facility	F 803	F803: SS=D MENUS MEET RESIDENT NEEDS/PREP IN ADV/FOLLOWED	5/10/23

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F 803	Continued From page 32 failed to consistently provide a physician ordered nutritional supplement at mealtimes for 1 of 2 residents (Resident #102) reviewed for food. This deficient practice was evidenced by the following: On 03/21/2023 at 11:16 AM, while on the initial facility tour of the facility, Resident #102's [redacted] complained that the food is wrong when meals are delivered. Resident #102's [redacted] also complained that he/she won't eat sometimes and that he/she has lost about [redacted] since [redacted]. Resident #102's [redacted] stated, "I'm here twice a day every day for lunch and dinner." On 03/23/2023 at 08:31 AM, the surveyor observed Resident #102 in their room during the breakfast meal. The surveyor reviewed Resident #102's breakfast meal ticket after receiving resident approval. The meal ticket revealed that Resident #102 was to receive a [redacted]) diet on 3/23/2023 at Breakfast. In addition, the meal ticket indicated that Resident #102 was to receive a EX. Order 26.(4) B1 Health Shake. No [redacted] Health Shake was observed on resident #102's tray at this meal. The surveyor immediately interviewed the Licensed Practical Nurse (LPN#1) assigned to Resident #102 that day and shift. The surveyor asked LPN #1 if Health Shakes prescribed to residents in the facility were provided by nursing staff or the facility kitchen. LPN #1 stated, "Health Shakes are provided from the kitchen. Nursing does not provide them." On 03/28/2023 at 08:27 AM, the surveyor observed Resident #102 in their room. Resident #102 had already finished eating the breakfast	F 803	I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: • The Dietary staff responsible for resident #102 were educated on Meal Tray accuracy and ensuring Health shakes are placed on the residents' tray as ordered. • The Nurses responsible for resident # 102 were educated on ensuring the resident received the health shake before signing the EMR. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: • All residents with orders for Health Shakes have the potential to be affected. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: • Dietary staff were educated on ensuring health shakes are placed on meal trays as ordered. • Licensed Nurses were educated on ensuring residents with orders for health shakes received their shakes on their trays prior to signing the EMAR. • The dietary manager or supervisor will observe the tray line for each meal with a list of residents with orders for Health shakes and mark shake present on tray next to resident. • The dietician will conduct an audit on residents with orders for health shakes to ensure there is an order in place, the	

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F 803	Continued From page 33 meal at this time. The surveyor left the room and went to the hallway to look for Resident #102's breakfast tray on the meal cart used to return the trays to the facility kitchen. The surveyor was able to find Resident #102's breakfast tray on the meal cart, as identified by Resident #102's breakfast meal ticket lying on the tray. Observation of the meal tray revealed that no [redacted] Health Shake was provided on the tray at this meal. On 03/31/2023 at 11:52 AM, the surveyor observed Resident #102 and [redacted] in in the room with the [redacted] assisting resident #102 with the lunch meal. Resident #102's meal ticket for the lunch meal, dated 03/31/2023, revealed that Resident #102 was to receive a [redacted] Health Shake with the lunch meal. No [redacted] health Shake was present on Resident #102's lunch meal tray, as observed by surveyor and resident [redacted]. LPN #1 was asked to come into the room at 11:56 AM by the surveyor. The surveyor showed the meal ticket to LPN #1 and LPN #1 agreed that Resident #102 should have received a Health Shake with the lunch meal and that the resident did not receive one. LPN#1 left room to get a [redacted] Health Shake for Resident #102. According to the Admission Face Sheet Resident #102's was admitted to the facility with diagnoses including but mot limited to: [redacted]	F 803	health shake is on the meal ticket and dietary and nursing staff are educated on ensuring the shake is on the tray as ordered. IV. MONITORING OF CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: • The Dietician will audit the trays on the unit of 10 residents with orders for health shakes weekly for 4 weeks and then monthly to ensure the health shakes are present on the trays. • The results of the audits will be reviewed by the Dietician during the quarterly QAPI Committee. • The quarterly QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. V. COMPLETION DATE: May 10, 2023	

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F 803	Continued From page 34	F 803		

A review of the comprehensive Resident Assessment Instrument/Minimum Data Set (MDS), an assessment tool, dated [redacted] revealed that Resident #102 had a Brief Interview for Mental Status Score of [redacted], indicating [redacted] According to section G of the MDS, Resident #102 required extensive assist of one for most activities of daily living. Section [redacted] of the MDS revealed that Resident #102 had not had any significant [redacted] and that Resident #102 received a therapeutic diet. Section N of the MDS revealed that Resident #102 received a [redacted] medication (a medication used to help [redacted] and [redacted]) daily.

A review of Resident #102's Physician Order Form, dated [redacted] revealed that Resident #102 had a physician order, dated [redacted] Foods/Supplements: [redacted] 1 carton by Mouth 3 times daily Note: [redacted].

According to Resident #102's Care Plan Report, date established [redacted], Resident #102 had a Problem indicator of "Potential [redacted] problem r/t (related to) [redacted] Goals were defined as follows: Labs WNL (within normal limits), I will maintain PO (by mouth) intakes >50% or more most meals with >75% or more of fluids consumed through the next review, I will maintain within CBW (current bodyweight) range as possible through next review, and supplement acceptance, start [redacted] Care planned Interventions included the following: Dietitian to monitor nutritionally, monitor for malnutrition,

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F 803	Continued From page 35 significant changes in weight, changes in PO intakes and follow up as needed, monitor labs as ordered, monitor weight x 4 weekly and monthly, provide diet as ordered: regular [redacted], provide assistance and provide EX. Order 26.(4) B1 (Health Shake) TID (three times a day) for additional [redacted] calories and [redacted] g (grams) of protein per serving with meals. On 03/30/2023 at 10:16 AM, the surveyor conducted an interview with the facility registered dietitian (RD). The RD explained, "He/she has a history of being on [redacted] medication and remains on [redacted] medication for fluid retention secondary to [redacted]. I spoke with him/her, and the [redacted] comes twice a day. The [redacted] provided me with food preferences, and he/she did not like EX. Order 26.(4) B1 (a liquid nutritional supplement specifically designed for EX. Order 26.(4) B1), so I switched to EX. Order 26.(4) B1 Health Shake." On 03/30/2023 at 02:26 PM, the surveyor interviewed Resident #102's [redacted] after the lunch meal which they assisted the resident in eating. When asked if Resident #102 had received the [redacted] Health Shake the [redacted] stated that the shake was not present on the tray at lunch and said, "I guess I'll have to ask for it." On 03/31/2023 at 12:04 PM, the surveyor interviewed the facility RD. The surveyor asked the RD what the purpose of the Health Shake was ordered for Resident #102 three times a day. The RD responded, "The Health Shakes are [redacted]. The intent of the Health Shake was to provide supplemental calories and protein due to a variable appetite and a history of EX. Order 26.(4) B1. The current order is	F 803		

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F 803	Continued From page 36 the Health Shake is to be provided three times a day at each meal." On 03/31/2023 at 12:12 PM, the surveyor entered the facility kitchen and observed the lunch tray line still in progress. The surveyor observed a white plastic container that contained Health Shakes in the cold holding well of the tray line. According to the Director of Dining after looking at Resident #102's lunch meal ticket on 3/31/2023, she agreed that Resident #102 was to receive a [redacted] Health Shake with meals. The DOD further revealed that the last person on the tray line is responsible to ensure that all menu items are to be on the tray before loading the meal tray onto the delivery cart. On 03/31/2023 at 01:17 PM, during an interview with the facility administration, including the Licensed Nursing Home Administrator and Vice President of Clinical Services (VPCS), the VPCS specified that, "Nursing or CNA (certified nursing assistant) staff, whoever is passing the meal tray to the resident is responsible for ensuring the accuracy of the meal tray for the resident." The facility did not provide a policy or procedure pertaining to meal tray accuracy.	F 803		
F 812 SS=E	NJAC 18:39-17.4(a)(1) Food Procurement,Store/Prepare/Serve-Sanitary 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,	F 812		5/10/23

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F 812	Continued From page 37 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, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 03/21/2023 from 9:33 to 10:13 AM, the surveyor accompanied by the Director of Dietary (DOD), observed the following in the kitchen: 1. In the pot and pan drying rack area of the kitchen a stack of third pans on a middle shelf were in the inverted position and stacked upon each other. The surveyor removed the top third pan from the stack and observed a wet, watery substance on the outside of the pan below. The DOD stated, "That's wet nesting." The DOD removed the third pans from the drying rack. Next to the third pans the surveyor removed a	F 812	F812: SS=E FOOD PROCUREMENT, STORE, PREPARE/SERVE-SANITARY I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: No residents were identified. • The pans identified were rewashed and angled on drying rack to prevent pooling or nesting water. • Meat Slicer was cleaned and sanitized, and cover was placed over the meat slicer. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: • All residents have the potential to be affected.	

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F 812	Continued From page 38 sixth pan from the top of approximately 6 pans that were inverted and stacked upon each other. The surveyor and DOD observed a wet and watery substance on the external surface of the pan below. The DOD removed the sixth pans from the drying rack 2. In the prep station area a cleaned and sanitized meat slicer was on the prep counter. The meat slicer was uncovered and exposed. The DOD agreed that the meat slicer was cleaned and sanitized and not in use at the time. The surveyor reviewed the facility policy with SUBJECT: WET NESTING OF KITCHEN WARES, dated 02/02/2023. The policy revealed the following under INTENT: Kitchen will wash, rinse, sanitize and air dry (when wet) all pots, pans, cook ware, service wares and small wares following each meal. Items will not be force dried with any type of rags or wipes. In addition, the following guidance was revealed under PROCEDURE: 1. When using dish machine. a) After items have been properly cleaned, rinsed, and sanitized and items are still wet staff will stack or angle pans in such a way on a designated clean "air drying" rack so they may completely dry prior to usage without any pooling or nesting water visible or touch. 2. When using pot and pan 3 compartment sinks. a). After items have been properly cleaned, rinsed, and sanitized, items will be stacked or angled in such a way on a designated clean "air	F 812	III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: • Dietary personnel were educated on the facility policy for Wet nesting of kitchen wares. • Dietary personnel were educated on ensuring equipment is covered after it is properly clean, sanitized, and dried. • The dietary manager or supervisor will audit washed pans after each meal for proper air-drying technique to ensure there is no pooling or wet nesting. • Any areas found to be out of compliance will be immediately addressed with additional education or disciplinary measures when required. • The dietary manager will audit food preparation equipment daily to ensure it is covered after being cleaned, sanitized, and dried. IV. MONITORING OF CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: • The administrator or designee will audit the kitchen 3 times a week for 4 weeks and then weekly for 3 months to ensure pans that are washed, rinsed, and sanitized are left to air dry on the air-drying rack in such a way they can air dry prior to usage without any pooling or nesting water is visible. • The administrator or designee will audit the kitchen 3 times a week for 4	

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F 812	Continued From page 39 drying" rack so they may completely dry prior to usage without any pooling or nesting water visible or touch. The facility did not provide a policy/procedure for storage of cleaned and sanitized food preparation equipment. NJAC 18:39-17.2 (g)	F 812	weeks and then weekly for 3 months to ensure all food preparation equipment is stored and covered appropriately after being cleaned, rinsed, sanitized, and air dried. • The results of the audits will be reviewed by administrator or designee during the QAPI Committee. • The QAPI Committee that is held quarterly will make recommendations based upon the results of the audits. • Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. V. COMPLETION DATE: May 10, 2023	
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. 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 provide a sanitary environment for residents, staff, and the public by failing to have a cover over the opening of 1 of 2 garbage dumpsters. This deficient practice was evidenced by the following: On 3/31/2023 at approximately 10:00 AM, the surveyor, accompanied by the facility Director of Dietary (DOD went outside the facility to the designated garbage area. Upon arriving the surveyor observed 3 green dumpsters that had (2) black plastic lids on each dumpster to cover the contents. The DOD explained that 2 of the 3	F 814	F814: SS=D Dispose Garbage and Refuse Properly I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: • No residents were identified. • The lid for the dumpster was closed by the Director of Dietary. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	5/10/23

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F 814	Continued From page 40 dumpsters were designated for garbage and (1) dumpster was designated for recycling materials. The middle dumpster had 1 of 2 black plastic lids open. The surveyor visually inspected the contents of the dumpster and observed bagged garbage from the facility. On interview the DOD stated that the dietary department and housekeeping department were responsible for the maintenance of the facility garbage area. The DOD also stated that the garbage dumpsters should be always covered. The surveyor reviewed a facility policy/procedure titled Food and Nutrition Services, date: 02/01/2023. The following was revealed under the heading PROCEDURE: 16. The facility will dispose of garbage and refuse properly, garbage and refuse containers will be maintained in good condition, and garbage receptacles will be covered when transported to the dumpster from the kitchen. NJAC 8:39-19.3(c)	F 814	• All residents and neighbors have the potential to be affected. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: • Dietary and Housekeeping personnel were educated on the facility policy for Garbage and Refuse Disposal. • The Director of Housekeeping or supervisor will check the dumpster area twice daily to ensure the dumpsters are in good condition and are covered. • Any areas found to be out of compliance will be immediately addressed with additional education or disciplinary measures when required. IV. MONITORING OF CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: • The administrator or designee will audit the dumpster area 3 times a week for 4 weeks and then weekly for 3 months to ensure the dumpsters are in good condition and the lids are closed. • The results of the audits will be reviewed by the Administrator or designee during the quarterly QAPI Committee. • The QAPI Committee will make recommendations based upon the results of the audits. • Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. V. COMPLETION DATE: May 10, 2023	

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to	F 842		5/10/23

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 04/03/2023

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

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F 842	Continued From page 42 coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C/O # NJ 00153588 Based on interview, review of the medical record and other facility documentation, it was determined that the facility failed to maintain a complete medical record for 1 of 28 sampled residents (Resident #138). This deficient practice	F 842	K 842: S/S = D Resident Records- Identifiable Information Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and	

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F 842	Continued From page 43 was evidenced by the following: Resident #138 was in the facility for [redacted] During a review of the closed medical record the facility Admission Face Sheet revealed that Resident # 138 was admitted to the facility with diagnoses including but not limited to; [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated [redacted] revealed a Brief Interview for Mental Status score of [redacted] indicating Resident # 138 was [redacted]. Section I of the MDS indicated an active diagnosis of [redacted]. Section K revealed [redacted] height [redacted]. A review of a computer-generated vital signs and monitoring sheet indicated resident #138 had weight of [redacted] but did not include a date. A review of the nutritional assessment dated [redacted] revealed a prescribed diet of [redacted]	F 842	foreseeable deficiency specifically by not ensuring maintaining of a complete medical record. The deficient practice was identified in 1 of 28 sampled residents, Resident #138. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #138 is no longer in the facility as he/she was discharged home. Resident was not adversely affected by the deficient practice. Medical Records was educated on 3/31/23 for the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. Medical Records checked like resident discharge records to ensure compliance. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ Medical Records was educated by Administrator on the deficient practice. ¿ The Administrator or designee will audit 5 closed records Monthly for 3 months and then quarterly for 3 quarters to ensure completion of medical records.	

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F 842	Continued From page 44 [redacted], regular, thin liquids. EX. Order 26.(4) B1 ounces twice a day, no chewing or swallowing difficulty, feeds self, appetite good EX. Order 26.(4) B1. BMI (body mass index) EX. Order 26.(4) B1. Resident feeding self at lunch. No reported problems chewing/swallowing and no [redacted]. Resident stated he/she had a EX. Order 26.(4) B1 at hospital but is now mostly normal. Resident states at home he/she drinks EX. Order 26.(4) [redacted] BID (twice a day) and eats 3 meals/day. Resident had no question/concerns r/t (related to) diet. RD (registered dietician) to provide preferences to the kitchen. Resident states he/she was EX. Order 26.(4) B1 a year ago but thinks he/she was [redacted] prior to hospitalization. Under Recommendations, continue current diet, provide ensure twice a day to promote weight maintenance/gain. continue to encourage good intake at meals. goal to maintain CBW (current body weight) with gradua EX. Order 26.(4) B1 to BMI WNL (within normal limits) for age, continue to monitor, continue POC (plan of care). A review of the care plan for Resident # 138 reflected under Problems: I have a potential nutrition problem and at risk for EX. Order 26.(4) B1 EX. Order 26.(4) B1. The following was revealed under Goals: I will maintain PO (oral) intakes >[redacted] or more at most meals with [redacted] or more of fluids consumed thru next review. I will maintain within CBW range as possible thru next review. Interventions included consult with dietician quarterly, monitor labs as ordered, monitor weight as ordered, offer extra fluids/hydrate unless contraindicated, provide diet as ordered. During an interview with the surveyor on	F 842	IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Administrator or designee will conduct audits of closed medical records monthly for 3 months, then quarterly for 3 quarters to ensure maintenance medical records in accordance with 483.70. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. V. COMPLETION DATE: May 10, 2023	

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F 842	Continued From page 45 03/28/2023 at 10:50 AM, Registered Nurse (RN #2) stated the facility weight policy is get a resident weight upon admission and then weekly weights on Monday, I think until they go home. RN #2 went on to say they are written on a paper at the desk and once they are done, we have a weight book on the unit. We keep the weight book and when full for the month we take out the papers and we give them to medical records, and she keeps everything. I think the way the system is set up we can only put in admission weights into the electronic medical record (EMR). During an interview with the surveyor at the same time and date, Unit Manager/Registered Nurse (UM/RN #1) said the Certified Nursing Assistants do meal consumption monitoring daily. Each resident gets their own ADL (Activities of daily living such as bathing, eating, dressing) sheet and when the resident leaves, we put it in front of the chart with the discharge paperwork and then medical records comes and takes the chart. UM/RN#1 went on to say that if a resident is discharged to the hospital, we will wait about week to see if they are coming back and if no wet put the ADL sheet in the front of the chart and Medical Records comes and gets the chart. On 03/28/2023 at 11:10 AM, the surveyor requested from the Director of Nursing (DON) and Vice President of Clinical Services (VPCS) the weights from admission and up to discharge, as well as the ADL sheets for Resident #138. The DON and VPCS said they will ask the receptionist who will know where they are, referring to the weekly weight sheets from the unit. The DON went on to say the weights should be entered into the medical record when they	F 842		

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F 842	Continued From page 46 (staff) obtain them. During an interview with the surveyor on 03/28/2023 at 12:59 PM, Certified Nursing Assistant #1 said we take resident weights at admission and every Monday until discharged or when requested by family. On 03/29/2023 at 08:46 AM, during a follow-up interview with the surveyor, the VPCS said she couldn't find weights or ADL sheets for Resident #138, as requested by the surveyor. The VPCS said, "Yeah, the medical record is incomplete. The weight sheet is actually a work sheet and not part of the medical record. The weights should be entered into the EMR. The nursing team does paper worksheets for weights and then the dietician looks at the weights and enters them into the system." The VPCS further stated that Resident #138 did have a weight on admission and then 1 other time but wasn't here that long. On 03/29/2023 at 09:49 AM, the VPCS came back and told the surveyor the only weight they have is [redacted]. During an interview with the surveyor on 03/31/2023 at 01:42 PM, the VPCS stated, "Absolutely, the medical records should be complete. When a patient is discharged the whole chart goes to Medical Records. This includes ADL sheets and weights." A review of a facility policy titled Medical Records dated 02/01/2023 revealed under the Intent section: It is the policy of the facility to maintain Medical Records in accordance with State and Federal regulations. Under Procedure section 2:	F 842		

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F 842	Continued From page 47 The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, systemically organized and include: ..... NJAC 8:39-35.2-(d)(9)	F 842		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315514		5/11/2023

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 F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 05/10/2023	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	
4/3/2023	☐ 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
	01001	A. BUILDING: _____ B. WING _____	C 04/03/2023

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C/O # NJ 00153588 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 9 of 14-day shifts and deficient in total staff for residents on 1 of 14 overnight shifts. 1. 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	S-560 - 8:39-5.1(a) Mandatory Access to Care □ STATE□S STAFFING RATIOS I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ 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 hire CNA□s, direct nursing staff include the following: Aggressively running ads through various social media platforms;	5/10/23

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

Electronically Signed | 04/19/23

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S 560	Continued From page 1 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 the weeks of 03/05/2023 to 03/11/2023 and 03/12/2023 to 03/18/2023 showed that the facility was deficient in CNA staffing for residents on 9 of 14-day shifts and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -03/05/23 had 10 CNAs for 112 residents on the day shift, required 14 CNAs. -03/09/23 had 12 CNAs for 112 residents on the day shift, required 14 CNAs. -03/10/23 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. -03/11/23 had 13 CNAs for 110 residents on the day shift, required 14 CNAs. -03/12/23 had 10 CNAs for 111 residents on the day shift, required 14 CNAs. -03/14/23 had 13 CNAs for 111 residents on the day shift, required 14 CNAs. -03/15/23 had 13 CNAs for 111 residents	S 560	Utilization of employment application websites; and fostering partnerships with recruitment and employment agencies. No residents have been adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this situation. III. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ Facility□s Recruitment and Retention Strategies and Efforts have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Offer daily and weekend bonuses to attract overtime or PRN staff shifts o Regularly meet with Staff to boost morale o Conduct Staff Appreciation programs and activities to promote Staff Retention o Aggressively run ads in various social media platforms and employment application websites o Flexible shifts and schedules o Increased wages to be well above state minimum o Working with C.N.A. schools to recruit new grads o Contract with staffing agencies	

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S 560	Continued From page 2 on the day shift, required 14 CNAs. -03/17/23 had 12 CNAs for 109 residents on the day shift, required 14 CNAs. -03/18/23 had 11 CNAs for 107 residents on the day shift, required 13 CNAs. -03/18/23 had 7 total staff for 107 residents on the overnight shift, required 8 total staff. During an interview with the surveyor on 03/30/2023 at 10:39 AM, the Staffing Coordinator said that yes, she is aware of the required CNA to resident ratio mandates. When asked if the facility was meeting the minimum requirements she replied, "Yes, we meet those requirements. Sometimes we have callouts, but we cover them." During an interview with the surveyor on 03/31/2023 at 1:30 PM, the Licensed Nursing Home Administrator (LNHA) said yes, I am aware of the staffing ratio mandate, when asked by the surveyor. The LNHA went on to say that most of the time we are meeting the ratios.	S 560	IV. MONITORING OF CORRECTIVE ACTIONS ¿ The Director of Nursing will provide weekly reports to the Administrator regarding all efforts made to try to comply with the State□s Staffing Ratios. Reports will be submitted to the Corporate Director of Human Resources/Payroll. ¿ Corporate Director of Human Resources/Payroll will submit monthly reports to the QAPI (Quality Assurance and Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further action plans. COMPLETION DATE: 5/10/2023	
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment.	S1405		5/10/23

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S1405	Continued From page 3 The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of 5 recently hired employee files, it was determined that the facility failed to ensure that 2 of 5 newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: On 03/27/2023 at 11:00 AM, the surveyor reviewed the employee files of five random and recently hired employees. Employee # 1 was hired on [redacted] and the physical was completed on [redacted]. The employee had the physical approximately 4 years prior to hire. Employee #2 was hired on [redacted] and their physical was completed on [redacted]. The employee received their physical approximately 2.5 months prior to hire.	S1405	S1405: Mandatory Infection Control and Sanitation Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable deficiency specifically by not ensuring that 1 of 5 newly hired employees received the Mantoux tuberculin test upon hir. The deficient practice was identified in 1 of 5 new employee files reviewed. V. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: All residents have the potential to be affected. Employee #1 and Employee #2 completed a health history and examination on 4/17/23. In addition, all current employee health files were audited for compliance. VI. IDENTIFICATION OF RESIDENTS	

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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) COMPLETE DATE
S1405	Continued From page 4 During an interview with the surveyor on 03/27/2023 at 12:48 PM, the Human Resources Director (HRD) was asked when are new employee required to get a physical? The HRD said if the employee hasn't had one in the past six months to a year, they will schedule a physical through the facility or their physician. The HRD said that new employees are given a 2-week window to get a physical completed from their date of hire. The HRD confirmed that employee #1 had their physical on [redacted] and employee #2 had their physical [redacted]. HRD said the physicals were not within 2 weeks of their date of hire.	S1405	WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. X. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: On March 31, 2023, Administrator educated HRD on NJ 8:39-19.59(a) A new hire check list was developed to establish criteria for determining the timely completeness of physical examinations for employees. Prior to a new employee starting, the Administrator will sign off on employee personnel file to include timely completeness of physical examinations. XI. MONITORING OF CORRECTIVE ACTIONS: The administrator will audit the new hire files weekly for 4 weeks and then monthly for 3 months to ensure timely completeness of physical examinations. The results of the audits will be reviewed during the QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. XII. COMPLETION DATE: 5/10/23	

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 04/03/2023

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

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S1410	Continued From page 5	S1410		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility records, it was determined that the facility failed to ensure that 1 of 5 newly hired employees received the Mantoux tuberculin test (a test to check if a person has been infected with TB bacteria) upon hire as required. This deficient practice was identified for 1 of 5 new employee files reviewed	S1410	S1410 Mandatory Infection Control and Sanitation Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and	5/10/23

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S1410	Continued From page 6 and is evidenced by the following: On 03/27/2023 at 11:00 AM, a review of new employee files revealed the following: Employee #1 had a Mantoux on 10/10/2018. During an interview with the surveyor on 03/27/2023 at 12:48 PM, the Human Resources Director (HRD) was asked when are new employees required to get a Mantoux. The HRD replied, new employees should have Mantoux upon hire via the facility and the 1st step completed during orientation. The HRD confirmed that employee #1 had their Mantoux on 10/10/2018.	S1410	foreseeable deficiency specifically by not ensuring that 1 of 5 newly hired employees received the Mantoux tuberculin test upon hir. The deficient practice was identified in 1 of 5 new employee files reviewed. What corrective action will be accomplished for those residents affected by the deficient practice? No residents were identified. All residents have the potential to be affected. Employee #1 will have a new Mantoux test on 4/27/23. In addition, all current employee health files were audited for compliance to ensure all employees had a twostep Mantoux test and or x ray complete. How will you identify other residents having the potential to be affected by the deficient practice and what corrective action will be taken? All residents have the potential to be affected. Employee #1 will have a new Mantoux test on 4/27/23. In addition, all current employee health files were audited for compliance to ensure all employees had a two step Mantoux test and or x ray complete. What measures will be put into place or what systemic changes have you made to ensure the deficient practice will not reoccur?	

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S1410	Continued From page 7	S1410	On March 31, 2023, Administrator educated HRD on NJ 8:39-19.59(b) A new hire check list was developed to establish criteria for determining the timely completeness of a two-step Mantoux test and/or X-ray (as applicable) for employees. Prior to a new employee starting, the Administrator will sign off on employee personnel file to include timely completeness of a two-step Mantoux test and/or X-ray. How will the corrective actions be monitored to ensure the deficient practice will not reoccur? (QA Programs). The administrator will audit the new hire files weekly for 4 weeks and then monthly for 3 months to ensure timely completeness of a two-step Mantoux test and/or X-ray. The results of the audits will be reviewed during the QAPI Committee. The QAPI Committee will make recommendations based upon the results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the continuation of the audits. Completion Date: 5/10/23	

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	315514	A. BUILDING **01** B. WING _____	**04/03/2023**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/24/2023 and 03/27/2023 and Excell Care at Egg Harbor 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Excell Care at Egg Harbor is a Two-story, Type II Fire Resistant building that was built in January 1980. The facility is divided into 6 smoke zones. The facility has one Diesel emergency generator.	K 000		
K 222 SS=E	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 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	K 222		5/10/23

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

Electronically Signed | 04/19/2023

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K 222	Continued From page 1 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 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.	K 222		

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K 222	Continued From page 2 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 03/24/2023 and 03/27/2023, it was determined that the facility failed to provide 1 of 9 exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 03/24/2023 (day one of survey) during the survey entrance at approximately 08:35 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are nine (9) designated exit discharge doors (illuminated exit signs above doors) for Residents to use during an evacuation in the facility. Starting at approximately 09:03 AM on 03/24/2023 and continued on 03/27/2023, in the presence of the facility's Admin and MA a tour of the building was performed. During the building tour the surveyor observed the following: 1) On 03/27/2023 at approximately 09:06 AM,	K 222	8) K222: S/S = E Egress Doors Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically having a thumb turn security locking device and fastening device on the front main sliding doors. The deficient practice was identified in 1 of 1 sliding door locations. VII. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Maintenance Director immediately disabled the lock and device to make it permanently nonfunctional. No residents were adversely affected by the deficient practice. VIII.IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR:	

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K 222	Continued From page 3 the surveyor observed the main entrance set of automatic sliding exit discharge doors (external set of doors) revealed thumb turn lock on the egress side. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. The Admin. and MA confirmed the findings at the time of observations. On 03/27/2023 during the survey exit at approximately 01:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222	¿ The Maintenance Director was educated by Administrator on K222 definition and details. ¿ Director of Maintenance or designee will include observation of the outside smoking areas to ensure safety and cleanliness when conducting daily environmental rounds. ¿ The Director of Maintenance checked all sliding doors to ensure deficient practice was corrected. XIII.MONITORING OF CORRECTIVE ACTIONS: ¿ The administrator or Designee will conduct Observation Rounds of all sliding doors weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that the sliding doors always remain unlocked. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. XIV. COMPLETION DATE: 5/10/ 2023	
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced	K 271		5/10/23

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K 271	Continued From page 4 by: Based on observations and review of facility provided documentation on 03/24/2023 and 03/27/2023 in the presence of facility management, it was determined that the facility failed to provide a suitable surface for evacuation at 1 of 9 designated exit discharges that would serve residents in an evacuation route. This deficient practice was evidenced by the following: On 03/24/2023 (day one of survey) during the survey entrance at approximately 08:35 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are nine (9) designated exit discharge doors (illuminated exit signs above doors) for Residents use during an evacuation in the facility. During the building tour in the presence of the Admin and MA the surveyor observed the following, 1. On 03/27/2023 at 9:40 AM, the surveyor observed that the activity room had one designated exit discharge door and the dining room had one designated exit discharge door that lead to a fenced-in resident smoking area patio. The patio area had a gate that opened to a 75 to 100 foot long black mulch and unleveled	K 271	K 271: S/S = E Discharge from Exits Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically by not providing the proper leveled concrete suitable surface emergency path located from the fenced in resident smoking are patio gate, to the fire road. The deficient practice was identified in 1 of 9 designated exit discharges that would serve residents in an evacuation route. IX. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Maintenance Director called to schedule a company to come quote and concrete the designated exit discharge path. No residents were adversely affected by the deficient practice. X. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. XV. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL	

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K 271	Continued From page 5 grass path to the fire road. The Admin and MA confirmed the finding at the time of observation. On 03/27/2023 during the survey exit at approximately 01:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. Life Safety Code 101 - 18.2.7 NJAC 8:39-31.2(e)	K 271	NOT RECUR: ¿ The Maintenance Director was educated by Administrator on k271 definition and details. ¿ Director of Maintenance or designee will include observation of the designated exit surfaces for evacuation ensure safety and compliance when conducting daily environmental rounds. ¿ The Director of Maintenance checked all designated exit discharge surfaces to ensure no other deficient practices were present. XVI. MONITORING OF CORRECTIVE ACTIONS: ¿ The Maintenance Director or designee will conduct Observation Rounds of all designated surfaces for evacuation weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that the suitable surfaces for evacuation are in place. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. XVII. COMPLETION DATE: 5/10/ 2023	
K 281 SS=E	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	K 281		5/10/23

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K 281	Continued From page 6 capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations on 03/24/2023 and 03/27/2023, it was determined that the facility failed to ensure continuous illumination for 2 of 9 designated exit discharges were provided and arranged so that the failure of any single lighting unit did not result in an illumination level of less than 0.2 ft-candle in any designated area in accordance with NFPA 101 Life Safety Code (2021 edition) Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4 The evidence includes the following, On 03/24/2023 (day one of survey) during the survey entrance at approximately 08:35 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that there are nine (9) designated exit discharge doors (illuminated exit signs above doors) for Residents to use during an evacuation in the facility. Starting at approximately 09:03 AM on 03/24/2023 and continued on 03/27/2023, in the presence of the facility's Admin and MA a tour of the building was performed and the surveyor observed the following on 03/27/2023:	K 281	K 281: S/S = E Illumination of Means of Egress Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically by not providing continuous illumination for designated exit discharges. The deficient practice was identified in 2 of 9 designated exit discharges. XI. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Maintenance Director installed proper continuous lighting in accordance with NFPA 101 life safety code Sections 7.8.1.1, 7.8.1.2 and 7.8.1.4 in 2 of 9 deficient locations. No residents were adversely affected by the deficient practice. XII. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. XVIII. MEASURES PUT INTO PLACE	

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K 281	Continued From page 7 1. At approximately 09:06 AM, the surveyor observed outside the stairwell exit discharge door, next to resident room [redacted], had a single light bulb fixture. 2. At approximately 09:37 AM, the surveyor observed outside the exit discharge door, next to resident room [redacted] had a single light bulb fixture. The Admin and MA confirmed the finding at the time of observation. On 03/27/2023 during the survey exit at approximately 01:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. N.J.A.C. 8:39 -31.2 (e) NFPA 101 2012 -19.2.8	K 281	OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The Director of Maintenance checked all designated exit discharge locations to ensure proper continuous illumination was installed and working properly. The Maintenance Director was educated by Administrator on K281 definition and details. Director of Maintenance or designee will include observation of the designated exit discharges ensure safety and compliance when conducting weekly environmental rounds. XIX. MONITORING OF CORRECTIVE ACTIONS: ¿ The Maintenance Director or designee will conduct Observation Rounds of all designated discharge exits weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that the continuous lighting need to meet code is in place. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. XX. COMPLETION DATE: 5/10/ 2023	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K 291		5/10/23

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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 291	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/24/2023, in the presence of facility management, it was determined that the facility failed to: Provide a battery backup emergency light above one (1) of two (2) emergency generator's transfer switches, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 03/24/2023 (day one of survey) during the survey entrance at approximately 08:35 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) if the facility had an Emergency Generator. The Admin told the surveyor, yes we a Diesel Generator. Starting at approximately 09:03 AM on 03/24/2023, in the presence of the facility's Admin. and MA, a tour of the facility was conducted. During the tour the surveyor observed the following, At approximately 09:18 AM an inspection in the basement level electrical area identified two (2) emergency generator transfer switches. The surveyor observed no evidence of a battery back up emergency light for the generators "Life Safety Branch" transfer switch. The Admin and MA confirmed the finding at the time of observation.	K 291	K 291: S/S = D Emergency Lighting Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically by not providing a battery backup emergency light above 1 of 2 emergency generator's transfer switches, independent of the building's electrical system and emergency generator. The deficient practice was identified in 1 of 2 emergency generator locations. XIII.CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Maintenance Director installed a proper battery backup emergency light above the 1 emergency generator's transfer switch in accordance with NFPA 101:2012-7.9,19.2.9.1 in 1 of 2 deficient locations. No residents were adversely affected by the deficient practice. XIV. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice.	

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 _____	**04/03/2023**

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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K 291	Continued From page 9 On 03/27/2023, during the survey exit at approximately 1:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	XXI. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The Maintenance Director was educated by the Administrator on k291 definition and details. ¿ Director of Maintenance or designee will include observation of the designated emergency generator transfer switch locations to ensure safety and compliance when conducting weekly environmental rounds. ¿ The Director of Maintenance checked emergency generator transfer switch locations to ensure proper battery backup emergency lighting was installed and working properly. XXII. MONITORING OF CORRECTIVE ACTIONS: ¿ The Maintenance Director or designee will conduct Observation Rounds of all designated emergency generator transfer switch locations weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that the continuous lighting need to meet code is in place. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. XXIII. COMPLETION DATE: 5/10/ 2023	
K 521 SS=E	HVAC CFR(s): NFPA 101	K 521		5/10/23

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	315514	A. BUILDING **01** B. WING _____	**04/03/2023**

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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K 521	Continued From page 10 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations on 03/24/2023 and 03/27/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 5 of 10 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 03/24/2023 (day one of survey) during the survey entrance at approximately 08:35 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a two-story building with 66 Resident sleeping rooms and various common areas.	K 521	K 521: S/S = E HVAC Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically by not ensuring that the facility's ventilation systems were being properly maintained for 5 of 10 Resident bathroom exhaust systems as per NFPA 90A.The deficient practice was identified in 5 of 10 resident bathroom locations. XV. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Maintenance Director ensured repair of facility's ventilation systems as per NFPA 90A. No residents were adversely affected by the deficient practice.	

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

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K 521	Continued From page 11 Starting at approximately 09:03 AM on 03/24/2023 and continued on 03/27/2023, in the presence of the facility's Admin and MA, a tour of the building was performed. During the two day tour, the surveyor inspected and tested ten (10) Resident sleeping rooms bathroom exhaust systems. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 5 of 10 resident bathrooms in the following locations: On 03/24/2023, 1. At approximately 09:58 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. At that time, the surveyor informed the Admin and MA that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:20 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. On 03/27/2023, 3. At approximately 09:31 AM, inside Resident room #[redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical	K 521	XVI. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. XXIV. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The Maintenance Director was educated by Administrator on K521 definition and details. ¿ Director of Maintenance or designee will include observation of resident bathroom exhaust systems to ensure safety and proper performance of resident bathroom exhaust systems when conducting daily environmental rounds. ¿ The Director of Maintenance checked all other Resident bathroom exhaust systems to ensure functionality as per NFPA 90A. XXV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Maintenance Director or designee will conduct Observation Rounds of 10 Resident bathroom exhaust systems weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that resident bathroom exhaust systems meet the NFPA 90A requirement. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for	

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 _____	**04/03/2023**

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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K 521	Continued From page 12 ventilation. 4. At approximately 09:53 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 10:05 AM, inside Resident room #[redacted] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The Admin. and MA confirmed the findings at the time of observations. On 03/27/2023 during the survey exit at approximately 01:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency.	K 521	further audits and/or action plans to ensure on-going compliance. XXVI. COMPLETION DATE: 5/10/ 2023	
K 911 SS=D	NFPA 90A. NJAC 8:39- 31.2 (e). 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	K 911		5/10/23

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K 911	Continued From page 13 by: Based on observation on 03/24/2023 and 03/27/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 24 electrical outlets located next to a water source (with-in 6 feet) was equipped with safe and secured Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: On 03/24/2023 (day one of survey) during the survey entrance at approximately 08:35 AM, a request was made to the Administrator (Admin) and Maintenance Assistant (MA) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified that the facility is a two-story building with 66 Resident sleeping rooms and various common areas. Starting at approximately 09:03 AM on 03/24/2023 and continued on 03/27/2023, in the presence of the facility's Admin and MA, a tour of the building was performed. During the two day tour, the surveyor observed and tested twenty four (24) electrical outlets (with-in 6 feet of a sink) in wet locations with a GFCI tester to de-energize the outlets. The surveyor observed the following: 1) On 03/24/2023 at approximately 09:55 AM, the surveyor observed inside Resident room [redacted] bathroom one (1) GFCI electrical outlet.	K 911	K 911: S/S = D Electrical Systems- other CFR(s): NFPA 101 Based on observation, interview, and review of pertinent facility documents, it was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically by not ensuring that 1 of 24 electrical outlets located next to a water source (within 6 feet) Resident bathroom exhaust systems as per NFPA 90A.The deficient practice was identified in 1 of 24 electrical outlets located next to a water source (within 6 feet). XVII. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ The Maintenance Director ensured replacement of GFCI in Resident [redacted] bathroom. No residents were adversely affected by the deficient practice. XVIII. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: ¿ All residents in the facility have the potential to be affected by the same deficient practice. XXVII. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE	

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K 911	Continued From page 14 When the surveyor tested the GFCI electrical outlet with a GFCI tester to de-energize, the GFCI electrical outlet did de-energize as required by code. When the surveyor pushed the re-set button, the GFCI electrical outlet had no electric power. At that time the surveyor requested the MA to push the re-set button to the GFCI outlet. The GFCI outlet could not restore electric power. The Admin and MA confirmed the finding at the time of observation. On 03/27/2023 during the survey exit at approximately 01:15 PM, the surveyor informed the Administrator of the Life Safety Code deficiency. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911	THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The Maintenance Director was educated by Administrator on K911 definition and details. ¿ Director of Maintenance or designee will include observation of resident GFCI outlets to ensure safety and proper performance of resident bathroom GFCI outlets when conducting daily environmental rounds. ¿ The Director of Maintenance checked all other Resident bathroom GFCI outlets to ensure safety and compliance with NFPA 101. XXVIII. MONITORING OF CORRECTIVE ACTIONS: ¿ The Maintenance Director or designee will conduct Observation Rounds of 5 Resident bathroom GFCI outlets weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that resident bathroom exhaust systems meet the NFPA 101 requirement. Audit results will be presented at the quarterly QAA Meeting. The QAPI Committee will determine the need for further audits and/or action plans to ensure on-going compliance. XXIX. COMPLETION DATE: 5/10/ 2023	

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	5/11/2023 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	05/10/2023	LSC K0271	05/10/2023	LSC K0281	05/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	05/10/2023	LSC K0521	05/10/2023	LSC K0911	05/10/2023
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	
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/3/2023	☐ YES ☐ NO