PRINTED:	08/31	/2023
FORM	APPR	OVED
	0030	0201

(X5) COMPLETION

DATE

CENTERS FOR MEDICARE & MEDICAID SERVICES JMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 000 **INITIAL COMMENTS** F 000 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 582 Medicaid/Medicare Coverage/Liability Notice F 582 5/10/23 SS=B 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

available in the facility and of charges for those LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

periodically during the resident's stay, of services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TITLE

04/19/2023

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 582 Continued From page 1 F 582 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 bv: Based on interview and review of other facility F582: SS=B documentation, it was determined that the facility Medicare Coverage/Liability Notice failed to issue the required beneficiary notice for This REQUIREMENT is not met as 1 of 3 residents (Resident #193) reviewed for the evidenced by: Based on interview and Beneficiary Protection Notification. This deficient review of other facility documentation, it practice was evidenced by the following: was determined that the facility failed to issue the required beneficiary notice for 1

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 2 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 582 Continued From page 2 F 582 On 03/22/2023 at 11:32 AM the surveyor of 3 residents (Resident #193) reviewed requested (3) random residents, (1) of whom for the Beneficiary Protection Notification. discharged to home (Resident #193) and (2) who remained in the facility to determine if the facility CORRECTIVE ACTIONS Ι. provided documentation of appropriate ACCOMPLISHED FOR RESIDENTS notifications FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 3/24/2023, the surveyor reviewed the SNF ż. Resident #193 is no longer in the (Skilled Nursing Facility) Beneficiary Protection facility as he/she was discharged home. Notification Review (SNFBPNR) completed by Resident was not adversely affected by the facility for Resident # 193. The SNFBPNR the deficient practice. indicated Resident # 193's last covered Medicare II. IDENTIFICATION OF RESIDENTS day was . A further review of the WHO HAVE THE POTENTIAL TO BE SNFBPNR further revealed that the AFFECTED BY THE SAME DEFICIENT facility/provider initiated the discharge from PRACTICE: Medicare Part A services when benefit days were All residents who are being ż not exhausted. The SNFBPNR indicated that a discharged from SNF (Skilled Nursing SNFABN form CMS-10055 was provided to the Facility) Medicare Part A Coverage have resident. The SNFBPNR also revealed that a the potential to be affected by the same Notice of Medicare Non-Coverage Form deficient practice. The Clinical CMS-10123 (NOMNC) was not provided to Reimbursement Coordinator/Consultant Resident #193 upon discharge to home.. The reviewed all residents who were section regarding the NOMNC included discharged from Medicare Part A services documentation that it was, "No, Not the correct since March 21, 2023, to ensure that the paperwork" Social Worker issued the appropriate Beneficiary Notice(s). No other residents During an interview with the surveyor on were affected. 03/28/2023 at 08:50 AM, the facility Social Worker (SW), when asked who determines what **III. MEASURES PUT INTO PLACE OR** forms are provided to residents discharged from SYSTEMIC CHANGES TO ENSURE Medicare A, she replied that for residents under THAT THE DEFICIENT PRACTICE WILL Medicare part A it is determined between NOT RECUR: therapy, SS (social services) and nursing. The The Social Workers and other ż SW went on to say that I do the SNFABN for members of the UR (Utilization Review) residents on Medicare A and we always give Team were in-serviced on the regulations them, regardless. If it is a resident-initiated re: Beneficiary Protection Notification. discharge, we do not give SNFABN. If facility Emphasis was made on promptly issuing initiated, we do give SNFABN, if we feel they the NOMNC (Notice Of Medicare

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 3 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 582 Continued From page 3 F 582 reached their goals and no longer require Non-Coverage) when a resident is being services. The surveyor then asked what about discharged from Medicare Part A residents discharged to home? The SW services. responded that either they get Managed Care The appropriate Beneficiary Notice(s) ż NOMNC or SNFABN. She further stated, "Yes, if that need to be issued for Medicare Part A a resident is discharged to home, they get a residents will be discussed and NOMNC and a SNFABN whether they stay in the incorporated in the Weekly UR (Utilization facility or discharge to home." Review) Meeting Form. The surveyor requested the SW review the IV. MONITORING OF CORRECTIVE SNFBPNR, and she said yes, he/she got ACTIONS TO ENSURE THAT THE SNFABN and because he/she was not managed DEFICIENT PRACTICE WILL NOT care he did not get NOMNC. When asked if **REOCCUR:** Resident #193 should have received NOMNC, The Administrator or Designee will ż the SW replied, "Yes he/she should have conduct Medical Record audits of 5 received a NOMNC from the facility as well." Discharged Medicare A beneficiaries per month x 6 months to ensure that the proper Beneficiary Notices are issued. NJAC 8:39-4.1(a)(7) 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 Develop/Implement Comprehensive Care Plan F 656 F 656 5/10/23 SS=D 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 -

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 4 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 656 Continued From page 4 F 656 (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: F 656 SS=D Based on observation, interview, record review and review of other facility documentation. it was Develop/Implement Comprehensive Care determined that the facility failed to develop a Plan

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

The REGULATORY OR LSCIDENTIFYING INFORMATION) The TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DMTE F 656 Continued From page 5 comprehensive, person-centered care plan for 3 of 28 sampled Resident #135). This deficient practice was evidenced by the following: 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 Resident #189 and host methods and y used since being hospitalized. F 656 A review of the Admission Face Sheet revealed Resident #189 was admitted to the facility with diagnoses including but not limited to: Improve of the most recent Minimum Data Set (MDS) an assessment tool used to facilitate care, dated interview for Mental Status score of I including the Physician Orders as of Include the use of include the use of Improvement of actione the Physician Orders as of Include the use of Improvement of actione the Physician Orders as of Include the use of Improvement of actione the Physician Orders as of Include the use of Improvement of actione the Resident #189's Care Plan did not include the use of Improvement of actione the Physician Orders as of Include the use of Improvement of actione the Physician Orders as of Include the use of Improvement of actione the Physician Orders as of Include the use of Improvement or wisewed Resident #189's Care Plan did not include the use of Improvement of actione the Physician Orders as of Include the use of Improvement of actione the Physician Orders as of Include the use of Improvement or wisewed Resident #189's care plan again and there was no care plan for Improvement of the Physician Orders as of Improvement or wisewed Resident #1			AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 08/31/2023 M APPROVED D. 0938-0391
315514 B. WING Out/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE_2P CODE 6818 DELILAH ROAD EXCEL CARE AT EGG HARBOR SUMMARY STATEMENT OF DEFICIENCIES, (#CACH DEFICIENCY MARKS STATEMENT OF DEFICIENCIES, (#CACH CORRECTON, CONCERTS PLAN, OF CORRECTION, (#CACH CORRECTON, CONCENTS HEP RECICIED BY FULL, REGULATORY OR LSCIDENTFYING INFORMATION) D D CARRON TOWNSHIP, NJ 08234 COMPETING (#CACH CORRECTON, CONCENTS HEP RECICIED BY FULL, REGULATORY OR LSCIDENTFYING INFORMATION) D D COMPETING (#CACH CORRECTON, CONCENTS) COMPETING (#CACH CORRECTON, CONCENTS) COMPETING (#CACH CORRECTON, CONCENTS) COMPETING (#CACH CORRECTON, CONCENTS) COMPETING (#CACH CORRECTON, INTERVIEW, RECORD (#CACH CORRECTON, CONCENTS) COMPETING (#CACH MERS) ESTATEST (#CACH ACTIONS) COMPETING (#CACH ACTIONS) CACH ACTIONS) CACH ACTIONS) CA	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				MPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STRE, ZIP CODE EXCEL CARE AT EGG HARBOR Bit DELLAH ROAD CMUID PREFIX TAG (BAUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAND OF CORRECTION (EACH DEFICIENCY MUST BE PROCEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS PLAND OF CORRECTION (EACH DEFICIENCY) F 656 Continued From page 5 or 28 sampled Residents, (Resident #189, Resident #48, and Resident #135). This deficient practice was evidenced by the following: F 656 1.) During the initial tour of the facility on 03/21/20/23 at 10:54 AM. Resident #189 was observed in bed with Immune. Resident #189 said he/she does not use since being hospitalized. F 656 A review of the Admission Face Sheet revealed Resident #189 was admitted to the facility with diagnoses including but not limited to: Indicating Resident #189 was admitted to the facility with diagnoses including but not limited to: Indicating Resident #189 was admitted to the facility with diagnoses including but not limited to: Indicating Resident #189 while a resident. A review of the Physician Orders as of Indicating Resident #189 while a resident. A review of Resident #189 while a resident. A review of Resident #189's Care Plan did not include the use of Include the use of Include the start #189's Care Plan and there was no care plan for Include the use of Include the start #189's Care Plan and there was no care plan for Include the use of Include Plan of Incellison Planters Include The Physican Orders as of			315514	B. WING	i	0	-
EXCEL CARE AT EGG HARBOR EGG HARBOR TOWNSHIP, NJ 08234 (X4) ID PREFIX NG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LISC DEMTIFYING INFORMATION) ID PREFIX PRESIX PROVIDERS PLAY OF CORRECTION (EACH DEFICIENCY) C(00) (EACH DEFICIENCY) F 656 Continued From page 5 comprehensive, person-centered care plan for 3 of 28 sampled Residents, (Resident #189, Resident #38, and Resident #135). This deficient practice was evidenced by the following: F 656 1.) During the initial tour of the facility on 03/21/2023 at 10:54 AM, Resident #189 was observed in bed with diagnoses including but not limited to since being hospitalized. F 656 A review of the Admission Face Sheet revealed Resident #189 was admitted to the facility with diagnoses including but not limited to include meuse cert of indicating Resident #189 was admitted to the facility with diagnoses including but not limited to moders as the facility of indicating Resident #189 was admitted to the facility with diagnoses including but not limited to moders as officient practice. The Care Plan of Resident #189 was admitted to the facility with diagnoses including but not limited to moders revealed under section C a Brief Interview of the Physician Orders as of moders as officient table proteint practice of not include the use of include	NAME OF F	PROVIDER OR SUPPLIER			S	•	
PREFX TAG TEACH CORRECT WARTING NO PREFX TAG TEACH CORRECTVE ACTION SHOULD BE CROSS-REFERENCE TO TAIL APPROPRIATE DEFICIENCY COMPLETION DATE F 656 Continued From page 5 comprehensive, person-centered care plan for 3 of 28 sampled Resident #139. This deficient practice was evidenced by the following: F 656 1.) During the initial tour of the facility on 03/21/2023 at 10:54 AM, Resident # 189 was observed in bed with diagnoses including but not limited to facient #189 was admitted to the facility with diagnoses including but not limited to MRESident #189 was admitted to the facility with diagnoses including but not limited to functive wor fine must recent Minimum Data Set (MDS) an assessment tool used to facilitate care, dated review of the Physician Orders as of 	EXCEL C	ARE AT EGG HARBC	R				
 comprehensive, person-centered care plan for 3 of 28 sampled Resident #189, Resident #138, and Resident #135, his 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 the sediment #189 was observed in bed with the sediment #189 was observed in bed with the sediment #189 was observed in use. Resident #189 said he/she does not use if the sediment #189 was admitted to the facility with diagnoses including but not limited to a facility and was discharged home. Resident #189 was admitted to the facility with diagnoses including but not limited to a facilitate care, dated for revealed nucler section C a Brief Interview for Mental Status score of Interview of the Physician Orders as of the sected #189 wile a resident. A review of the Physician Orders as of the wile a resident. A review of Resident #189's Care Plan did not include the use of facilitate care, plan sected #189 wile a resident. A review of Resident #189's Care Plan did not include the use of facility as the sected point and there was no care plan for use. A review of Resident #189's care plan again and there was no care plan for use. A review of Resident #189's care plan again and there was no care plan for use. A review of Resident #189's care plan again and there was no care plan for use. A review of Resident #189's care plan again and there was no care plan for use. 	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
During an interview with Surveyor #1 on Instrument) Process, with focus on	F 656	comprehensive, per of 28 sampled Resi Resident #48, and I practice was evider 1.) During the initial 03/21/2023 at 10:54 observed in bed with a since being hospital A review of the Adm Resident #189 was diagnoses including A review of the mose (MDS) an assessm dated for Menta indicating Resident Under Resident #189 A review of the Phy () A review of Resident include the use of On 03/27/2023 at 0 reviewed Resident there was no care p	rson-centered care plan for 3 dents, (Resident # 189, Resident #135). This deficient need by the following: tour of the facility on 4 AM, Resident # 189 was the set Resident #189 said he/she at home and has only used lized. hission Face Sheet revealed admitted to the facility with g but not limited to: st recent Minimum Data Set ent tool used to facilitate care, vealed under section C a Brief I Status score of #189 had section O the MDS indicated while a resident. sician Orders as of ht #189's Care Plan did not 9:39 AM, the surveyor #189's care plan again and plan for use.	F	356	 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) BT ¿ 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 WIL NOT RECUR: ¿ The Interdisciplinary Team members and Nursing Staff were in-serviced on the serviced on the serviced on the service of not have a serviced on the service of not have a service of a staff were in-serviced on the service of the service of not having Staff were in-serviced on the service of not have a service of not having comprehensive, person-centered care plans. 	e, / / / /

Event ID: POXK11

Facility ID: NJ01001

If continuation sheet Page 6 of 48

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING _	ON	FORM MB NO. (X3) DATE	08/31/2023 APPROVED 0938-0391 E SURVEY PLETED
		315514	B. WING			04/0	03/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	ARE AT EGG HARBO	R			818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	03/29/2023 at 09:23 Manager/Registere admitting nurse, Ur coordinator are res plans. UM/RN #1 w EX. Order 26.(4 (Activities of Daily L on antibiotic or has on the correct of the coordinator is to ad as if Diabetic and g the care plan. UM/F resident is to ad as if Diabetic and g the care plan. UM/F resident is to ad as if Diabetic and g the care plan. UM/F resident is to ad as if Diabetic and g the care plan. UM/F resident is to ad as if Diabetic and g the care plan. UM/F resident is to ad as if Diabetic and g the care plan. UM/F resident is to ad as if Diabetic and g the care plan. UM/F the care plan. UM/F the MDS coordinato anticoagulant, EX. anything else that r On 03/29/2023 at 0 requested UM/RN # care plan and tell th care planned. On 0 UM/RN #1 said, "N have care plan for "Yes", when asked plan for use During an interview 03/31/2023 at 01:2 Clinical Services (V	3 AM, Unit d Nurse (UM/RN #1) said the nit Manger and MDS ponsible for doing the care vent on to say she expects) B1 , ADL's living), side rails, falls and if an EX. Order 26.(4) B1 , and if re should be a care plan. explained that the MDS d any special disease, such etting EXEMPT it has to be on RN #1 confirmed that if a the surveyor would expect to <i>A</i> /RN #1 said that EXEMPT and D B1 are on by the admitting nurse and order in and it goes on UM/RN #1 explained that she dmission chart the next day ehensive care plan and then or goes in and adds Order 26.(4) B1 and needs to be done. 9:29 AM, Surveyor #1 #1 to look at Resident #189's he surveyor if EXEMPT use is 3/29/2023 at 09:31 AM, o, Resident #189 doesn't a " UM/RN #1 replied, should he/she have a care	Fθ	\$56	 developing a comprehensive, person-centered care plan for each resident, to meet each resident's m nursing, and mental and psychosod needs that are identified in the comprehensive assessment. IV. MONITORING OF CORRECTIACTIONS: The MDS Coordinator(s) or Detwill conduct 5 Care Plan Audits weet 4 weeks, then 5 Care Plan Audits m x 3 months. Audits will focus on vet the completion of a Comprehensive Person-centered Care Plan, to meet resident's medical, nursing, mental psychosocial needs that were ident the comprehensive assessment. Results of audits will be reported to Administrator monthly and presente the quarterly QAA Meeting. The Q/Committee will determine the need further audits and/or action plans for on-going compliance. V. COMPLETION DATE: May 10. 	vE signee ekly x nonthly erifying e at the and tified in o the ed in API for or	

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	()(0) 14		OI	FORM MB NO.	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •			COM	E SURVEY PLETED C
		315514	B. WING				03/2023
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL	ARE AT EGG HARBO)R		-	818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	We do the baseline comprehensive car hours to 7 days. Wi be on a care plan, to the patient. If they here rails,	e care plan in 48 hours and e plan as soon as possible, 72 hen asked what is expected to the VPCS replied, "A picture of nave a, side ,, side ,	F	656			

Facility ID: NJ01001

If continuation sheet Page 8 of 48

		AND HUMAN SERVICES					FORM	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION			E SURVEY PLETED
		315514	B. WING					,)3/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODI			
EXCEL C	ARE AT EGG HARBO)R			8818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 083	234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD	BE	(X5) COMPLETION DATE
F 656	included in the care On 03/31/2023 at 0	o plan. 01:13 PM, during an interview	FØ	356				
	should have a care with	he VPCS said residents plan if they are diagnosed . Further, the VPCS said ould be established within 72						
	3.) A review of Res revealed that he/sh	ident #135's closed record e passed away.						
	02/01/2023, located had a diagnosis of involving EX. Ord	nt #135's MDS dated d in the EMR, revealed he/she (disease ler 26.(4) B1). The ed that Resident #135						
	A review of Resider revealed orders for medication used to							
	with Surveyor #2, L)1:00 PM, during an interview JM/RN #1 confirmed that er had a care plan for						
	with Surveyor #2, the should have a care with	1:13 PM, during an interview he VPCS said residents plan if they are diagnosed . Further, the VPCS said should be established within 72						
	Resident Centered	y policy titled Comprehensive Care Plans, dated son-centered care plan						

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 656 Continued From page 9 F 656 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) Services Provided Meet Professional Standards F 658 F 658 5/10/23 SS=E 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, F 658: S/S =E and review of other facility documentation, it was Services Provided Meet Professional determined that the facility failed to a) maintain Standards Based on observation, interview, record professional standards of clinical practice by not review, and review of other facility following the physician's order for EX. Order parameters for 1 of 28 sampled residents documentation, it was determined that the (Resident # 29) and b) follow professional facility failed to a) maintain professional standards of nursing practices and facility policy standards of clinical practice by not by not notifying the Licensed Independent following the physician's order for blood Practitioner of a prescribed medication that was parameters for 1 of 28 not administered as ordered for 1 of 2 residents sampled residents (Resident # 29) and b) during a medication pass observation. follow professional standards of nursing practices and facility policy by not This deficient practice was evidenced by the notifving the Licensed Independent following: Practitioner of a prescribed medication that was not administered as ordered for

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: POXK11

Facility ID: NJ01001

If continuation sheet Page 10 of 48

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		LE CONSTRUCTION	COM	E SURVEY PLETED
		315514	B. WING	i			C 03/2023
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	ARE AT EGG HARBC	R			6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Reference: New Je 45 Chapter 11, Nurs Practice Act for the "the practice of nurs Professional Nurse treating human resp physical and emotion such services as can health counseling, a supportive to restor and executing medi by a licensed or oth Physician or dentist Reference: New Je 45, Chapter 11. Nur Practice Act for the "The practice of nur nurse is defined as responsibilities with finding; reinforcing to teaching program th counseling and pro- restorative care, un registered nurse or authorized physicia There was no adve According to the fac Resident #29 was a diagnoses including	resey Statutes, Annotated Title sing Board. The Nurse State of New Jersey states; sing as a Registered is defined as diagnosing, and ponse to actual or potential onal health problems, through use finding, health teaching, and provision of care ative of life and wellbeing, cal regimens as prescribed erwise legally authorized " rsey Statutes Annotated, Title sing Board. The Nurse State of New Jersey states: rsing as a licensed practical performing tasks and in the framework of case the patient and family prough health teaching, health vision of supportive and der the direction of a licensed or otherwise legally n or dentist." rse effect on Resident #29. cility Admission Face Sheet idmitted to the facility with but not limited to:	F	658	 1 of 2 residents during a medication observation. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTE THE DEFICIENT PRACTICE: <i>i</i> The Physician was notified by the Director of Nursing regarding the far some nurses to follow EX. Order 26. <i>i</i> parameters in the administration for Resident #29 fro <i>i</i> order 26.(4) B^T through EX.Order 20. <i>i</i> subsequently discontinued the parameters in the administration of parameters in the administration for Resident #29. Resident #29 was not adversely affed by the deficient practice. <i>i</i> The Director of Nursing/Designer counseled the nurses who failed to the physician's order for EX.Order 26. <i>i</i> parameters in the administration for Resident #29. Thurses were in-serviced on the importance of following Physician sordered, <i>i</i> LPN notified Physician of Reside that EX.Order 26.(4) B^T was not adminion 3/28/23 at 8:00 AM. No new ord given. LPN # 2 documented notification the resident s chart. LPN # 2 war re-educated on facility s policy on to do when a medication is not avail during Medication Administration. Resident #3 was not adversely affed 	S ED BY he ilure of (4) B1 on of m MD ected ee follow 4) B1 on of he s sers s lent #3 istered lers ation is what lable	

Event ID: POXK11

Facility ID: NJ01001

If continuation sheet Page 11 of 48

-	TH AND HUMAN SERVICES RE & MEDICAID SERVICES				FORM /	08/31/2023 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMF	E SURVEY PLETED
	315514	B. WING	G		04/0) 3/2023
NAME OF PROVIDER OR SUPPLI	ĒR	•		TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL CARE AT EGG HAP	BOR			818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
reviewed the Co Regimen Review EX. Order 26 as per ^{a co} paran On 03/29/23 at 7 the Electronic M (e-MAR) that sh administration a time of administ was obtained: A review of the N Market State (a con 03/12/2023 a On 03/12/2023 a On 03/14/2023 a On 03/20/2023 a	Medical Medical " t 10:26 AM, Surveyor #1 nsultant Pharmacist's Medication /* from the previous 6 months (4) B1 when was not held teter." 2:35 PM, the surveyor reviewed edication Administration Record owed the time of medication well as the X. Order 26(4) B1 at ation. The following information March 2023 e-MAR reflected that eld (not administered) on the ind times: t 12:00 PM the t 08:00 AM the	F	658	by the deficient practice. II. IDENTIFICATION OF RESIDEN WHO HAVE THE POTENTIAL TO E AFFECTED BY THE SAME DEFICE PRACTICE: ¿ All residents with MD Orders for medications, including residents on medications, including residents on medication administration Records (MARs) of active residents to ensur- no other residents were affected by same deficient practice. III. MEASURES PUT INTO PLACE SYSTEMIC CHANGES TO ENSUR THAT THE DEFICIENT PRACTICE NOT RECUR: ¿ All nurses were in-serviced on to need to maintain professional stand of clinical practice when following physician s orders with parameters on following professional standards nursing practices and facility policy a medication is not available. Empty was made on the following: (a) Administration of Medications according to the Physician's Order, (b) Adhering to the acceptable star of nursing practice related to followid physician's order in the administration medications with EX. Order 26.(4) E parameters. (c) Following facility s Policy wher medication is unavailable during	BE ENT r same nd surrent e that the E OR E WILL he lards s, and of when nasis	

Event ID: POXK11

Facility ID: NJ01001

If continuation sheet Page 12 of 48

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COM	E SURVEY PLETED
		315514	B. WING			(04/0))3/2023
NAME OF	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL 0	CARE AT EGG HARBC	R			818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	On $02/15/2023$ at 1 On $02/27/2023$ at 1 On $02/27/2023$ at 04 On $02/4/2023$ at 04 On $02/4/2023$ at 04 On $02/23/2023$ at 00 On $02/23/2023$ at 00 On $02/25/2023$ at 00 On $02/25/2023$ at 00 On $01/5/2023$ at 08 On $01/5/2023$ at 08 On $01/8/2023$ at 08 On $01/8/2023$ at 08 On $01/8/2023$ at 08 On $01/16/2023$ at 08 On $01/23/2023$ at 00 On $01/23/2023$ at 12 On $01/28/2023$ at 12 On $01/7/2023$ at 12 On $01/7/2023$ at 12 On $01/28/2023$ at 04 On $01/28/2023$ at 04 On $01/28/2023$ at 04 On $03/29/2023$ at 00 interviewed the Inter the urise to first che follow it as directed parameter such as nurse must first che Options on the e-M document the SX.01	2:00 PM the 2:00 PM the 2:00 PM the 2:00 PM the 2:00 PM the 4:00 PM the 4:00 PM the 4:00 PM the 4:00 PM the 4:00 PM the 4:00 PM the 2:00 AM the 2:00 PM the 2:00 PM the 2:00 PM the	F6	658	Medication Pass. (d) Notifying the Physician when medications are not administered as ordered. IV. MONITORING OF CORRECTIVA ACTIONS: ¿ Unit Managers or designee will review the Medication Administration Records (MARs) of 10 residents x 3 months, to check whether medication are administered in accordance with physician s orders, including comple with (X, Order 26(4)) (M) parameters if ordered. If medications were not given to a resident, medical records will be revento to ensure that the physician was not and that it is documented in accordation with facility s policy. Findings will be reported to the Direct Nursing and Administrator monthly at will be presented at the quarterly QA Meeting. The QAPI Committee will determine the need for further audits and/or action plan. V. COMPLETION DATE: May 10, 2	/E n bins liance tified ance ctor of and AA s	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		315514	B. WING	;			C 03/2023
NAME OF I	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
EXCEL	ARE AT EGG HARBC	R			6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	If the medication is checks "administered an option to click "m e-MAR will either re- the medications wa indicating that the m The surveyor them m Pharmacist's Medic month of February w indicated that there regarding the admin outside of parameter that, the Assistant D was notified. The IL was the previous Al remembered the re- On 03/31/2023 at 0 interviewed the Vice Services (VPCS) in team. The surveyor medication of the parameters a the concern stating EX. Order 26.(4) BT " A review of the facil Administration Polic 3/1/2023, did not in regarding medication NJAC 8:39-27.1(a) According to the Add	administered, the nurse ed." If the medication is held tot given" is checked. The effect a check indicating that s administered or an X nedication was not given. reviewed the Consultant cation Regimen Review for the with the IUM. The report were administration errors histration of given and given ers. The report also stated Director of Nursing (ADON) JM acknowledged that she DON and that she port. 1:18 PM, the surveyor e President of Clinical the presence of the survey reviewed the findings of the being administered outside and the VPCS acknowledged , "The resident could become hity's Medication cy and Procedure dated clude documentation on parameters.	F	658			

					FOF	ED: 08/31/2023 RM APPROVED IO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OATE SURVEY OMPLETED
	315514	B. WING	i		(C)4/03/2023
ROVIDER OR SUPPLIER					1	
ARE AT EGG HARBO	R				234	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETION DATE
Continued From pa	ge 14	Fe	658	8		
conducted a medica Resident #3. Licens searched the medic here," referring to packet. LPN #2 pro- indicating that the medic here," referring to packet LPN #2 pro- indicating that the medic A review of Resider revealed an order for packet (8:00 AM and 4:00 EX. Order 26.(4) B1 A review of the Medic (MAR) revealed that EX. Order 26.(4) B1 for the 8 During an interview 03/30/2023 at 12:57 #1 what is your pro- not available in the	ation pass observation for sed Practical Nurse (LPN #2) cation cart then stated," its not (gram) ceeded to select the box nedication was not given. It #3's Physician Order Form or " PM) Diagnosis Described: with a start date of dication Administration Record it the 08:00 AM dose of s not administered on 8:00 AM dose. with Surveyor #2 on 7 PM, Surveyor #2 asked LPN cess when medications are medication cart during					
the doctor for media sometimes the doct given, sometimes the alternative while the During an interview 04/03/2023 at 11:27 the 08:00 AM dose administered on 03 replied, "No" when	cations that are not available, tor Ok's for one dose not to be ne doctor will recommend an e medication is not here yet." with Surveyor #2 on 7 AM, the IUM confirmed that of the top was not /28/2023. In addition, the IUM asked was the doctor notified					
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER CARE AT EGG HARBO SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa Continued From pa Conducted a medica Resident #3. Licens searched the medica here," referring to packet. LPN #2 pro indicating that the medica here, referring to packet. LPN #2 pro indicating that the medica here, referring to packet [] (8:00 AM and 4:00 EX. Order 20(4) B1 A review of the Medo (MAR) revealed that SUMMARY STA (8:00 AM and 4:00 EX. Order 20(4) B1 for the A During an interview 03/30/2023 at 12:57 #1 what is your pro- not available in the medication administing the doctor for medica sometimes the doct given, sometimes the alternative while the During an interview 04/03/2023 at 11:27 the 08:00 AM dose administered on 03 replied, "No" when	IDENTIFICATION NUMBER: 315514 PROVIDER OR SUPPLIER SARE AT EGG HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 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 (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 (gram) packet (8:00 AM and 4:00 PM) Diagnosis Described: (8:00 AM and 4:00 PM) Diagnosis Described: (MAR) revealed that the 08:00 AM dose of (MAR) revealed that the 08:00 AM dose of (MAR) revealed that the 08:00 AM dose of (MAR) revealed that the 08:00 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 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	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (FCORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MU A. BUILD 315514 PROVIDER OR SUPPLIER CARE AT EGG HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREF TAGE Continued From page 14 F M 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 graph (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 " packet" (8:00 AM and 4:00 PM) Diagnosis Described: (8:00 AM and 4:00 PM) Diagnosis Described: (9:00m/28)(19) A review of the Medication Administration Record (MAR) revealed that the 08:00 AM dose of (MAR) revealed that the 08:00 AM dose of (3:00m/28)(19) 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	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIA A. BUILDIN B. WING STONDER OR SUPPLIER 315514 B. WING RRE AT EGG HARBOR ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 14 F 653 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 macket. 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 " macket for the 8:00 AM dose of max not administration Record (MAR) revealed that the 08:00 AM dose of max not administration cart during medication administration cart during medication administration. LPN #1 replied, "call the doctor for medication cart during medication administration. LPN #1 replied, "call the doctor for medication sthat are not available, sometimes the doctor OK's for one dose not to be given, sometimes the doctor OK's for one dose not to be given, 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 max not administered on 03/28/2023. In addition, the IUM replied, "No" when asked wa	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (*1) PROVIDERSUPPLER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A. BUILDING 315514 B. WING 3ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELLAH ROAD EGG HARBOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LS: IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 14 F 658 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 market. 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 " packet 120 PM) Diagnosis Described: it counting to the Medication Administration Record (MAR) revealed that the 08:00 AM dose. During an interview with Surveyor #2 on 03/30/2023 at 12:57 PM, Surveyor #2 an 03/30/2023 at 12:57 PM, Surveyor #2 on 03/30/2023 at 11:27 AM, the IUM confirmed that the 06:00 AM dose of OV Whith asker of on the expention of the medication is not here yet." During an interview with Surveyor #2 on 03/30/2023 at 11:27 AM, the IUM confirmed that the 08:00 AM dose of OV Whot asked was the doctor notified	RS FOR MEDICARE & MEDICAID SERVICES OMB N OP DEFICIENCIES CORRECTION (X1) PROVIDERSUPPLENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) C 315514 B. WINO C PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE (B13 DELLIAH ROAD EGG HARBOR STREET ADDRESS, CITY, STATE, ZIP CODE (B14 DELLIAH ROAD EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEPICIENCIES (B20) DEPICIENCY MUST BE PRECIDED BY FULL (B20) DEPICIENCY ON LSC DENTIFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (B20) DEPICIENCY Continued From page 14 F 658 F 658 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 was not given. F 658 A review of Resident #3's Physician Order Form revealed an order for max and administered on a was not administered on a was not administered on a was not administered on a deministration. LPN #1 replied, "call the doctor for medication stat are not available, sometimes the doctor Will recommend an alternative while the medication is not here yet." During an interview with Surveyor #2 on 03/30/2023 at 11:27 AM, the IUM confirmed that the 06:00 AM dose of Was not addition, the IUM addition, the IUM

If continuation sheet Page 15 of 48

		AND HUMAN SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (COMI	E SURVEY PLETED
		315514	B. WING				C 03/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	ARE AT EGG HARBO	R			818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From pa	ge 15	F 6	658			
	03/31/2023 at 01:18 when medications a designated time, wh VPCS stated the nu automated medicat if it is not there they the doctor know, an	with Surveyor #2 on 8 PM, Surveyor #2 asked are not available at the hat is your process. The urse should check the backup ion dispensing machine, and v should call the physician, let nd whatever orders the give at that moment and call stat (rush) delivery.					
	administration-med 2/1/2023 revealed " medications as per protocol. Procedure medication is not av administration, the proceed to check m back up medication available in the faci will call the primary	y policy titled Medication dication availability, dated 'Our facility shall administer physician's order and e:4. In the event a vailable during medication licensed professional will nedication availability in the n box. If medication is not lity, the licensed professional physician for further narmacy will be informed					
F 689 SS=D		azards/Supervision/Devices 1)(2)	F 6	89			5/10/23
	§483.25(d)(2)Each	resident receives adequate					

Facility ID: NJ01001

If continuation sheet Page 16 of 48

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT OF DEFINAND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	COM	E SURVEY PLETED
		315514	B. WING				C 0 3/2023
NAME OF PROVIDE	R OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL CARE A	EGG HARBO	R			818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
supervised This R by: Based pertine that fa known reside open I service dentif was e On 03 observ survey R order Furthe plastic the lid clear, such a recept in sma On 03 with th Admin recept is the A revie	ents. EQUIREMEN d on observation ent facility doo cility failed to and foresee nts environm id garbage rec area. The ied in 1 of 1 of videnced by t /31/2023 at 1 /ation of the of vor observed average rec within the g plastic bag fill as a paper cu acle were ex all amount of /31/2023 at 0 plastic bag fill as a paper cu acle were ex all amount of /31/2023 at 0 plastic bag fill as a paper cu acle should the LNHA als area should the LNHA als	AT is not met as evidenced ion, interview, and review of cuments, it was determined identify and eliminate a able accident hazard in the ent specifically by leaving an oceptacle in the outside deficient practice was butside interview areas and he following: 1:10 AM during an butside interview area, the multiple extinguished ound throughout the area. for also observed a gray eptacle not fully covered by arbage receptacle was a led with combustible materials p. Also, within the garbage tinguished interview interview interview interview.	F	889	F689: S/S = D Accident Hazards/Supervision/Devi Based on observation, interview, ar review of pertinent facility documen was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the residents environment specifically b leaving an open lid garbage receptat the outside area. The define practice was identified in 1 of 1 outs smoking areas I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTE THE DEFICIENT PRACTICE: ; The plastic garbage receptacle outside area was immedia removed. The porter cleaned the out smoking area to ensure that there wand no foreseeable accident hazards. No residents were adversely affected the deficient practice. II. IDENTIFICATION OF RESIDENT WHO HAVE THE POTENTIAL TO TA AFFECTED BY THE SAME DEFIC PRACTICE: ; All residents who smoke in the outside areas have the po to be affected by the same deficient practice. The Director of Maintenar checked all of the areas areas to	nd its, it py acle in cient side TS ED BY in the ately utside were ed by NTS BE IENT tential t nce	

Facility ID: NJ01001

If continuation sheet Page 17 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 689 Continued From page 17 F 689 ensure that they were clean and free of NJAC:8:39-31.6(e) 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 areas remain that the outside clean and free of any foreseeable accident hazards. Director of Maintenance or designee Ś will include observation of the outside 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 areas weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that the outside 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 Bowel/Bladder Incontinence, Catheter, UTI F 690 5/10/23 F 690 SS=D CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 18 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 690 Continued From page 18 F 690 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 bv: Based on observation, interview, review of the 5) F690 SS=D medical record and review of other facility Bowel/Bladder Incontinence. Catheter. documentation, it was determined that the facility UTI failed to maintain resident dignity when the Based on observation, interview, review

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		315514	B. WING			C 04/03/2023			
NAME OF PROVIDER OR SUPPLIER EXCEL CARE AT EGG HARBOR				STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 690	EX. Order 26.(4) B1 b hallway and in the u Residents reviewed vas evidenced by t On 03/22/2023 at 0 observed Resident with his/her device during the irectly to the ex. Order produced during the) was obser resident stand under to Resident #87's was visible from the room. A review of the Adm Resident #87 was a diagnoses including A review of the Mini assessment tool us ex. Order 26.(4) B revealed Resident s A review of the Phy Resident # 87 inclu	ag was visible from the unit dining room for 1 of 2 for EX. Order 26.(4) B1 # 87). This deficient practice he following: 9:38 AM, the surveyor #87 in the unit dining room . The XXXXXXXIII bag (attaches 126.(4) B1 and EX. Order 20.(4) B1 e day and becomes rved to hanging next to the the wheelchair, not attached and below the was exposed, and hallway and in the dining hission Face Sheet revealed admitted to the facility with but not limited to: 10 imum Data Set (MDS), an ed to facilitate care, dated d Resident #87 had cognition. The MDS further #87 had an 10 sician Order sheet for ded an order for a	F	590	of the medical record and review of facility documentation, it was detern that the facility failed to maintain res- dignity when the EX. Order 26.(4) bag was visible from the hallway and the unit dining room for 1 of 2 Resic reviewed for EX. Order 26.(4) B (Resident # 87). I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTE THE DEFICIENT PRACTICE: ¿ Upon identification of the deficies practice, the urine catheter drainage of Resident #87 was covered with a bag by the Unit Manager. Certified nursing assistant who was assigned to Resident #87 was cour and in-serviced on ensuring that bag is covered with a bag is covered with a	nined sident B1 d in dents 1 TS ED BY ent e bag a seled a seled NTS BE IENT heter the the the ser			

Facility ID: NJ01001

If continuation sheet Page 20 of 48

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FORM MB NO. (X3) DATE	08/31/2023 APPROVED 0938-0391 E SURVEY PLETED
315514			B. WING			C 04/03/2023	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL CARE AT EGG HARBOR					318 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	x90 days, Resident days Interventions, all da not limited to. Change 10PM-6AM on Thur X076720(1) IEX. Order 20 Foley care q (every monitor and amount no EX. Order 26(4) B1 During an interview 03/22/2023 at 11:47 Manager/Registere when using a (residents), so the every 2 hours make and not exposed. T UM/RN #1 the evide exposed, and not a UM/RN #1 replied, way and should be times." During an interview 03/28/2023 at 11:14 Nursing (DON) told is that residents wit always have the they are, and it sho	A with the surveyor on 7 AM, Unit d Nurse (UM/RN#1) said , we put on them we surveyor showed the ence of the surveyor on 7 AM, Unit d Nurse (UM/RN#1) said , we put on them manual attached, covered, he surveyor showed the ence of the surveyor on tatached to Resident #87's ."It is not supposed to be that attached to his/her at all with the surveyor on A AM, the facility Director of the surveyor. "My expectation	F 6	90	 III. MEASURES PUT INTO PLACK SYSTEMIC CHANGES TO ENSUR THAT THE DEFICIENT PRACTICE NOT RECUR: i Nursing Staff were educated of proper care of residents with with emphasis on makin that weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(weekly x 3 months. Focus of audit on ensuring that EX. Order 26.(wea	RE WILL n g sure VE r audits) B1 ents' the nonthly lity uality rmine ction	

If continuation sheet Page 21 of 48

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED		
		315514	B. WING		04	/03/2023		
NAME OF PROVIDER OR SUPPLIER EXCEL CARE AT EGG HARBOR			68	STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 690	the was ob visible with ex- in the wheelchair v the unit dining room A review of a facilit Control-EX. Order 3/01/2023, reveale	to be that way when told that served hanging next to the posed while resident #87 was isiting with his/her	F 690					
F 755 SS=D	NJAC: 8.39-27.1(a Pharmacy Srvcs/Procedures/ CFR(s): 483.45(a)(§483.45 Pharmacy	Pharmacist/Records b)(1)-(3)	F 755			5/10/23		
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	ovide routine and emergency als to its residents, or obtain eement described in acility may permit unlicensed hister drugs if State law nder the general supervision of						
	pharmaceutical ser that assure the acc dispensing, and ad	ures. A facility must provide rvices (including procedures curate acquiring, receiving, ministering of all drugs and t the needs of each resident.						
		Consultation. The facility tain the services of a licensed						
	§483.45(b)(1) Prov	ides consultation on all						

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 755 Continued From page 22 F 755 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: F 755: SS=D Based on interview and review of other facility documentation, it was determined that the facility Pharmacy Services / procedures / failed to ensure that the incoming and outgoing Pharmacist / Records nurses reconciled controlled substances at Based on interview and review of other change of shift. This deficient practice was facility documentation, it was determined identified for 2 of 2 medication carts on 2 of 2 that the facility failed to ensure that the nursing units. incoming and outgoing nurses reconciled controlled substances at change of shift. The deficient practice was evidenced by the This deficient practice was identified for 2 of 2 medication carts on 2 of 2 nursing following: units. CORRECTIVE ACTIONS On 03/27/23 at 08:52 AM, the Surveyor reviewed Ι. the narcotic log book on the floor nursing unit ACCOMPLISHED FOR RESIDENTS medication cart. FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: A review of the Controlled Substance Inventory No residents were adversely affected log for the EX. Order 26.(4) B1 medication cart for by the deficient practice. All nurses were the month of March revealed that the signature of educated re: the need to reconcile the incoming nurse and/or signature of outgoing controlled substances at change of shift nurse was blank on the following days/times: to ensure accountability of controlled substances. 03/08/2023 10 PM Outgoing nurse 03/18/2023 10 PM Outgoing nurse II. IDENTIFICATION OF RESIDENTS 03/19/2023 6 AM Incoming nurse WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT 03/19/2023 10 PM Outgoing nurse

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 23 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 755 Continued From page 23 F 755 03/26/2023 3-11 PM Incoming nurse PRACTICE 03/26/2023 3- 11 PM outgoing nurse ¿ All residents have the potential to be 03/26/2023 11-7 PM Outgoing nurse affected by the same deficient practice. All the narcotic boxes in the medication A review of the Controlled Medication Account carts were checked to identify any Record for the EX. Order 26.(4) B1 medication cart discrepancies between the narcotic revealed that multiple sections were left blank on medication inventory and the declining the dates/shifts as follows: inventory sheets. No discrepancies were identified, and no residents were affected Total Count of items (Bingo Cards, bottles, by the deficient practice. boxes) 03/25/2023 7-3 PM, 3-11 PM, 11-7 AM shifts III. MEASURES PUT INTO PLACE OR 03/26/2023 7-3 PM and 3-11 PM shifts SYSTEMIC CHANGES TO ENSURE 03/27/2023 7-3 PM shift THAT THE DEFICIENT PRACTICE WILL NOT RECUR: # (Number) of new items received during this All licensed nurses were educated on shift the importance of proper documentation, i.e., the need to reconcile controlled 03/25/2023 3-11 PM shift 03/26/2023 7-3 PM, 3-11 PM, 11-7 AM shifts substances at change of shift to maintain accurate accountability and reconciliation Total # of declining sheets present for controlled medications in the facility. 03/25/2023 03/26/2023 IV. MONITORING OF CORRECTIVE 03/27/2023 ACTIONS: The Unit Managers or designee will ż On 03/29/2023 at 09:39 AM, the surveyor conduct audits of the Controlled reviewed the narcotic log book on the Substance Reconciliation Records in all units on a weekly basis x 4 weeks, then EX. Order 26.(4) B1 Cart. monthly thereafter x 2 months. Focus of the audits will be on ensuring that A review of the Controlled Medication Account Record for March revealed that the signature of incoming and outgoing shift nurses are the incoming nurse and/or signature of the reconciling controlled substances at outgoing nurse was blank on the following days: change of shift. Audit Findings will be reported to the Director of Nursing monthly and 03/01/2023 7-3 PM Outgoing nurse presented in the quarterly Quality 03/09/2023 7-3 PM Outgoing nurse 03/12/2023 3-11 PM Outgoing nurse Assurance Meeting. The QAPI (Quality Assurance and Performance 03/15/2023 7-3 PM Outgoing nurse

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 24 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 755 Continued From page 24 F 755 03/28/2023 3-11 PM Incoming nurse Improvement) Committee will determine 03/28/2023 11-7 AM Incoming nurse the need for further audits and/or action 03/28/2023 11-7 AM Outgoing nurse plans. A review of the Controlled Medication Account V. COMPLETION DATE: May 10, 2023 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 25 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 755 Continued From page 25 F 755 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 26 of 48

PRINTED: 08/31/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 755 Continued From page 26 F 755 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 756 Drug Regimen Review, Report Irregular, Act On F 756 5/10/23 SS=E 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 756 Continued From page 27 F 756 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 F756: SS = E other facility documentation, it was determined Drug Regimen Review, Report Irregular, that the facility a)failed to ensure that the Act On Consultant Pharmacist (CP) reported Based on interview, record review, and irregularities of drug regimen to the physician. review of other facility documentation, it and b.) failed to act upon the CP report of was determined that the facility a) failed irregularities found while reviewing the drug to ensure that the Consultant Pharmacist regimen. This deficient practice was identified for (CP) reported irregularities of drug 1 of 28 sampled residents, (Resident #29) and regimen to the physician, and b.) failed to was evidenced by the following: act upon the CP report of irregularities found while reviewing the drug regimen. There was no adverse effects to Resident #29. This deficient practice was identified for 1 of 28 sampled residents, (Resident #29) According to the Admission Face Sheet Resident #29 was admitted with diagnoses including but CORRECTIVE ACTION S Ι.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 28 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 756 Continued From page 28 F 756 not limited to: ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: According to the The Director of Nursing notified Physician Order ż. Sheet, resident #29 had an order dated Resident #29 s attending physician for an EX. Order 26.(4) B1 medication; regarding the failure of some nurses to Oral Tablet MG (milligram) follow the EX. Order 26.(4) B² tablet, 1 tablet by mouth times daily with parameters in the administration of "Special Instructions," (parameter) to hold the for Resident #29 from medication when the January 2023 through March 2023. The Pharmacy Consultant was Ś in-serviced by his/her supervisor re: On 03/27/2023 at 10:26 AM, the surveyor ensuring that he/she reports drug regimen irregularities to the physician. Focus was reviewed the Consultant Pharmacist's Medication Regimen Reviews (CPMRR) for the made on checking for compliance with months of January 2023 through March 2023.) parameters in the administration of . if For the month of January 2023, the Consultant ordered by physician. Pharmacist did not identify or report The Unit Manager who failed to act as ż being administered outside of parameters. upon Consultant Pharmacist s recommendations for Resident #29 was A review of the February 2023 the Consultant counseled and re-educated by the Pharmacist reported; Director of Nursing. ordered to be held if EX. Order 26.(4) B1 greater than -on 2/1/23 at 4 pm, on 2/4/23 at 4 pm and on Resident #29 was not adversely affected by the deficient practice. 2/7/23 at 8 AMEX. Order 26.(4) B1 was greater than but but was signed as II. IDENTIFICATION OF RESIDENTS administered. [nurses name] ADON was WHO HAVE THE POTENTIAL TO BE notified " AFFECTED BY THE SAME DEFICIENT PRACTICE The CPMRR created in March reported, All residents on with ż orders for EX. Order 2 **B1**) Multiple instances parameters are at risk for the same noted when medication was not held, 2/12 8 am deficient practice. Unit Managers and and 12 noon; 2/13 12 pm; 2/15 8 am and noon; Nursing Supervisors reviewed the current 2/16 8 am: 2/20 8 am: 2/23 4 pm: 2/25 4 pm: 2/28 Medication Administration Records 8 am-[nurses name], DON was notified." (MARs) of active residents on to ensure that no other residents were

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 29 of 48

		AND HUMAN SERVICES			ON	FORM. MB NO.	08/31/2023 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		315514	B. WING			04/03/2023	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL CARE AT EGG HARBOR					818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	On 03/29/2023 at 1 reviewed the Janua March 2023 Electro that included the M Records (e-MAR's) administered the m to Resident #29 wh 22 times and held when the was A review of the Mar March 2023 at 12:0 On 03/12/23 at 12:0 On 03/12/23 at 12:0 On 03/12/23 at 12:0 On 03/12/23 at 12:0 On 03/20/23 at 08:0 A review of the Feb that Was parameters X. Order On 02/7/2023 at 08 On 02/15/2023 at 0 On 02/15/2023 at 0 On 02/15/2023 at 1 On 02/15/2023 at 1 On 02/15/2023 at 1 On 02/15/2023 at 04 On 02/1/2023 at 04 On 02/1/2023 at 04	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 to Resident #29 when the was above 22 times and held X. Order 26.(4) B1 MG, 3 times when the was less than 2000 as follows: A review of the March 2023 e-MAR reflected that was held (not administered) on the following dates and times: On 03/12/23 at 12:00 PM the On 03/14/23 at 08:00 AM the On 03/20/23 at 08:00 AM the On 03/20/23 at 08:00 AM the On 03/20/23 at 08:00 AM the		756	affected by the same deficient prac No additional residents were identified III. MEASURES PUT INTO PLACE SYSTEMIC CHANGES TO ENSUR- THAT THE DEFICIENT PRACTICE NOT RECUR: ¿ Pharmacy Consultant and Nurs were in-serviced on the facility s P on Drug Regimen Review, with em- on ensuring that drug regimen irregularities are reported to the phy and recommendations by the Phar Consultant are acted upon. Focus made on ensuring compliance with X. Order 20:01151 parameters in the administration of parameters in the administration ordered. IV. MONITORING OF CORRECTI ACTIONS: ¿ The Director of Nursing or Desi will conduct Medical Review audits residents with orders for administration parameters in the administration of parameters in the administration of parameters in the administration of parameters in the administration of the Pharmacy Consultant to the Physician and, (2) Recommendation the Pharmacy Consultant are acted by the Unit Managers promptly. Any identified issues will be rectified addressed immediately. Audit Find will be reported to the Administrator monthly basis and reported in the O Meeting on a Quarterly Basis. The Committee will determine the need	fied. E OR E OR E WILL ses Policy phasis ysician macy was vas inen VE ignee on 5 (4) 61 on of (1) orted on s by d upon d and lings r on a QAPI QAPI	

Event ID: POXK11

Facility ID: NJ01001

If continuation sheet Page 30 of 48

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
315514			B. WING			C 04/03/2023	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL CARE AT EGG HARBOR					818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 756	A review of the Jan that was parameters for On 01/5/2023 at 08 On 01/8/2023 at 08 On 01/8/2023 at 08 On 01/16/2023 at 00 On 01/23/2023 at 12 On 01/2/2023 at 12 On 01/2/2023 at 12 On 01/28/2023 at 12 On 01/28/2023 at 12 On 01/28/203 at 04:0 The facility was una that the CPMRR re- given outside physi addressed by the n On 3/31/2023 at 1: ² interviewed the Vice Services (VPCS) in team and the Licen Administrator. The findings of the medi administer outside of VPCS acknowledge resident could becco	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 30 A review of the January 2023 e-MAR reflected hat was administered outside of the		756	further audits and or action plans of quarterly basis. COMPLETION DATE: May 10, 202		

Facility ID: NJ01001

If continuation sheet Page 31 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 756 Continued From page 31 F 756 and the director of nursing (DON). Under #4 and these reports will be acted upon. NJAC-8:39-29.3(a) F 803 Menus Meet Resident Nds/Prep in Adv/Followed F 803 5/10/23 SS=D 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 quidelines.; §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 bv: Based on observation, interview, review of the F803: SS=D medical record and review of other facility MENUS MEET RESIDENT documents, it was determined that the facility NEEDS/PREP IN ADV/FOLLOWED

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 32 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 803 Continued From page 32 F 803 failed to consistently provide a physician ordered CORRECTIVE ACTIONS 1 nutritional supplement at mealtimes for 1 of 2 ACCOMPLISHED FOR RESIDENTS residents (Resident #102) reviewed for food. This FOUND TO HAVE BEEN AFFECTED BY deficient practice was evidenced by the following: THE DEFICIENT PRACTICE: The Dietary staff responsible for • On 03/21/2023 at 11:16 AM, while on the initial resident #102 were educated on Meal facility tour of the facility, Resident #102's Tray accuracy and ensuring Health complained that the food is wrong when meals shakes are placed on the residents' tray are delivered. Resident #102's also as ordered. complained that he/she won't eat sometimes and The Nurses responsible for resident # that he/she has lost about since 102 were educated on ensuring the Resident #102's resident received the health shake before stated, "I'm here twice a day every day for lunch signing the EMR. **II. IDENTIFICATION OF RESIDENTS** and dinner." WHO HAVE THE POTENTIAL TO BE On 03/23/2023 at 08:31 AM, the surveyor AFFECTED BY THE SAME DEFICIENT observed Resident #102 in their room during the PRACTICE: breakfast meal. The surveyor reviewed Resident All residents with orders for Health #102's breakfast meal ticket after receiving Shakes have the potential to be affected. resident approval. The meal ticket revealed that **III. MEASURES PUT INTO PLACE OR** Resident #102 was to receive a SYSTEMIC CHANGES TO ENSURE) diet on 3/23/2023 at Breakfast. In THAT THE DEFICIENT PRACTICE WILL addition, the meal ticket indicated that Resident NOT RECUR: Dietary staff were educated on #102 was to receive a Order 26.(4) B1 Health Shake. No Health Shake was observed on ensuring health shakes are placed on resident #102's tray at this meal. The surveyor meal trays as ordered. immediately interviewed the Licensed Practical Licensed Nurses were educated on Nurse (LPN#1) assigned to Resident #102 that ensuring residents with orders for health day and shift. The surveyor asked LPN #1 if shakes received their shakes on their Health Shakes prescribed to residents in the trays prior to signing the EMAR. facility were provided by nursing staff or the The dietary manager or supervisor facility kitchen. LPN #1 stated, "Health Shakes will observe the tray line for each meal are provided from the kitchen. Nursing does not with a list of residents with orders for provide them." Health shakes and mark shake present on tray next to resident. The dietician will conduct an audit on On 03/28/2023 at 08:27 AM, the surveyor observed Resident #102 in their room. Resident residents with orders for health shakes to ensure there is an order in place, the #102 had already finished eating the breakfast

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 33 of 48

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391		
		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C				
		315514	B. WING) 03/2023		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
EXCEL C	ARE AT EGG HARBO	R		6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 803	meal at this time. The went to the hallway breakfast tray on the trays to the facility hable to find Resider meal cart, as identified breakfast meal ticked. Observation of the field breakfast meal ticked observed Resident room with the lunch meal for the lunch meal for the lunch meal for the lunch meal for the lunch meal that Resident #102 Shake with the lunch was present on Resident was present on Resident ticket to LI that Resident #102 Health Shake with the suth the suth the meal ticket to LI that Resident #102 Health Shake with the resident did not reciget a Health Shake with the suth the sut	he surveyor left the room and to look for Resident #102's e meal cart used to return the kitchen. The surveyor was at #102's breakfast tray on the fied by Resident #102's et lying on the tray. meal tray revealed that no provided on the tray at this 1:52 AM, the surveyor #102 and president #102 . Resident #102's meal ticket dated 03/31/2023, revealed was to receive a Health the meal. No health Shake sident #102's lunch meal tray, veyor and resident for the room at rveyor. The surveyor showed PN #1 and LPN #1 agreed should have received a the lunch meal and that the eive one. LPN#1 left room to ake for Resident #102.	F٤	803	health shake is on the meal ticket a dietary and nursing staff are educa ensuring the shake is on the tray as ordered. IV. MONITORING OF CORRECTH ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT REOCCUR: • The Dietician will audit the tray the unit of 10 residents with orders health shakes weekly for 4 weeks a then monthly to ensure the health s 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 make recommendations based upor results of the audits. Upon attaining consistent compliance, the QAPI committee will determine the contir of the audits. V. COMPLETION DATE: May 10,	ted on s VE s on for and shakes e will on the g nuation			

Facility ID: NJ01001

If continuation sheet Page 34 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 803 Continued From page 34 F 803 A review of the comprehensive Resident Assessment Instrument/Minimum Data Set (MDS), an assessment tool, dated revealed that Resident #102 had a Brief Interview for Mental Status Score of , indicating According to section G of the MDS, Resident #102 required extensive assist of one for most activities of daily living. Section of the MDS revealed that Resident #102 had not had any significant and that Resident #102 received a therapeutic diet. Section N of the MDS revealed that Resident #102 received a medication (a medication used to help and and ally. A review of Resident #102's Physician Order Form, dated revealed that Resident #102 had a physician order, dated Foods/Supplements: 1 carton by Mouth 3 times daily Note: According to Resident #102's Care Plan Report, date established , Resident #102 had a Problem indicator of "Potential problem r/t (related to) EX. Order 26.(4) B1 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, star Care planned Interventions included the following: Dietitian to monitor nutritionally, monitor for malnutrition,

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 35 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 803 Continued From page 35 F 803 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 , provide assistance and provide der 26.(4) B1 (Health Shake) TID (three times a day) for additional calories and 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 medication and remains on medication for fluid retention secondary to . I spoke with him/her, and the comes twice a day. The provided me with food preferences, and he/she did not like (a liquid nutritional supplement specifically designed for so I switched to Health Shake. On 03/30/2023 at 02:26 PM, the surveyor interviewed Resident #102's after the lunch meal which they assisted the resident in eating. When asked if Resident #102 had received the Health Shake the 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 . The intent of the Health Shake was to provide supplemental calories and protein due to a variable appetite

FORM CMS-2567(02-99) Previous Versions Obsolete

and a history of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X4) ID

PRÉFIX

TAG

. The current order is

Facility ID: NJ01001

If continuation sheet Page 36 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 803 Continued From page 36 F 803 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 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. NJAC 18:39-17.4(a)(1) Food Procurement, Store/Prepare/Serve-Sanitary F 812 F 812 5/10/23 SS=E 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 37 of 48

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 812 Continued From page 37 F 812 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 bv: F812: SS=E Based on observation, interview, and review of other facility documentation, it was determined FOOD PROCUREMENT, STORE, that the facility failed to handle potentially PREPARE/SERVE-SANITARY hazardous food and maintain sanitation in a safe CORRECTIVE ACTIONS and consistent manner to prevent food borne Ι. illness. This deficient practice was evidenced by ACCOMPLISHED FOR RESIDENTS the following: FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 03/21/2023 from 9:33 to 10:13 AM, the No residents were identified. surveyor accompanied by the Director of Dietary The pans identified were rewashed (DOD), observed the following in the kitchen: and angled on drying rack to prevent pooling or nesting water. 1. In the pot and pan drying rack area of the Meat Slicer was cleaned and kitchen a stack of third pans on a middle shelf sanitized, and cover was placed over the were in the inverted position and stacked upon meat slicer. each other. The surveyor removed the top third II. IDENTIFICATION OF RESIDENTS pan from the stack and observed a wet, watery WHO HAVE THE POTENTIAL TO BE substance on the outside of the pan below. The AFFECTED BY THE SAME DEFICIENT DOD stated, "That's wet nesting." The DOD PRACTICE: removed the third pans from the drying rack. All residents have the potential to be Next to the third pans the surveyor removed a affected.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 812 Continued From page 38 F 812 sixth pan from the top of approximately 6 pans that were inverted and stacked upon each other. **III. MEASURES PUT INTO PLACE OR** The surveyor and DOD observed a wet and SYSTEMIC CHANGES TO ENSURE watery substance on the external surface of the THAT THE DEFICIENT PRACTICE WILL pan below. The DOD removed the sixth pans NOT RECUR: from the drying rack Dietary personnel were educated on the facility policy for Wet nesting of 2. In the prep station area a cleaned and kitchen wares. sanitized meat slicer was on the prep counter. Dietary personnel were educated on The meat slicer was uncovered and exposed. ensuring equipment is covered after it is The DOD agreed that the meat slicer was properly clean, sanitized, and dried. cleaned and sanitized and not in use at the time. The dietary manager or supervisor will audit washed pans after each meal for The surveyor reviewed the facility policy with proper air-drying technique to ensure SUBJECT: WET NESTING OF KITCHEN there is no pooling or wet nesting. WARES, dated 02/02/2023. The policy revealed Any areas found to be out of the following under INTENT: Kitchen will wash, compliance will be immediately addressed with additional education or rinse, sanitize and air dry (when wet) all pots, pans, cook ware, service wares and small wares disciplinary measures when required. following each meal. Items will not be force dried The dietary manager will audit food with any type of rags or wipes. In addition, the preparation equipment daily to ensure it is following guidance was revealed under covered after being cleaned, sanitized, PROCEDURE: and dried. 1. When using dish machine. IV. MONITORING OF CORRECTIVE ACTIONS TO ENSURE THAT THE a) After items have been properly cleaned, DEFICIENT PRACTICE WILL NOT rinsed, and sanitized and items are still wet staff REOCCUR: will stack or angle pans in such a way on a The administrator or designee will designated clean "air drying" rack so they may audit the kitchen 3 times a week for 4 completely dry prior to usage without any pooling weeks and then weekly for 3 months to or nesting water visible or touch. ensure pans that are washed, rinsed, and sanitized are left to air dry on the 2. When using pot and pan 3 compartment sinks. air-drying rack in such a way they can air dry prior to usage without any pooling or nesting water is visible. a). After items have been properly cleaned, rinsed, and sanitized, items will be stacked or The administrator or designee will angled in such a way on a designated clean "air audit the kitchen 3 times a week for 4

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 812 Continued From page 39 F 812 drying" rack so they may completely dry prior to weeks and then weekly for 3 months to usage without any pooling or nesting water ensure all food preparation equipment is visible or touch. stored and covered appropriately after being cleaned, rinsed, sanitized, and air dried. The facility did not provide a policy/procedure for storage of cleaned and sanitized food The results of the audits will be preparation equipment. reviewed by administrator or designee during the QAPI Committee. NJAC 18:39-17.2 (g) The QAPI Committee that is held guarterly 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 **Dispose Garbage and Refuse Properly** F 814 5/10/23 F 814 CFR(s): 483.60(i)(4) SS=D §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced bv: Based on observation, interview, and review of F814: SS=D other facility documentation, it was determined Dispose Garbage and Refuse Properly 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 CORRECTIVE ACTIONS 1 garbage dumpsters. This deficient practice was ACCOMPLISHED FOR RESIDENTS evidenced by the following: FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: On 3/31/2023 at approximately 10:00 AM, the No residents were identified. surveyor, accompanied by the facility Director of The lid for the dumpster was closed Dietary (DOD went outside the facility to the by the Director of Dietary. II. IDENTIFICATION OF RESIDENTS designated garbage area. Upon arriving the surveyor observed 3 green dumpsters that had WHO HAVE THE POTENTIAL TO BE (2) black plastic lids on each dumpster to cover AFFECTED BY THE SAME DEFICIENT the contents. The DOD explained that 2 of the 3 PRACTICE:

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 40 of 48

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 814 Continued From page 40 F 814 dumpsters were designated for garbage and (1) All residents and neighbors have the dumpster was designated for recycling materials. potential to be affected. The middle dumpster had 1 of 2 black plastic lids open. The surveyor visually inspected the III. MEASURES PUT INTO PLACE OR contents of the dumpster and observed bagged SYSTEMIC CHANGES TO ENSURE garbage from the facility. On interview the DOD THAT THE DEFICIENT PRACTICE WILL stated that the dietary department and NOT RECUR: housekeeping department were responsible for Dietary and Housekeeping personnel the maintenance of the facility garbage area. The were educated on the facility policy for DOD also stated that the garbage dumpsters Garbage and Refuse Disposal. should be always covered. The Director of Housekeeping or supervisor will check the dumpster area The surveyor reviewed a facility policy/procedure twice daily to ensure the dumpsters are in titled Food and Nutrition Services, date: good condition and are covered. 02/01/2023. The following was revealed under Any areas found to be out of the heading PROCEDURE: compliance will be immediately addressed with additional education or disciplinary measures when required. 16. The facility will dispose of garbage and refuse properly, garbage and refuse containers will be IV. MONITORING OF CORRECTIVE maintained in good condition, and garbage ACTIONS TO ENSURE THAT THE receptacles will be covered when transported to DEFICIENT PRACTICE WILL NOT the dumpster from the kitchen. REOCCUR: The administrator or designee will audit the dumpster area 3 times a week NJAC 8:39-19.3(c) 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

PRINTED: 08/31/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 842 Resident Records - Identifiable Information F 842 5/10/23 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) SS=D §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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

PRINTED: 08/31/2023 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING С 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 842 Continued From page 42 F 842 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 bv: K 842: S/S = D C/O # NJ 00153588 **Resident Records- Identifiable** Based on interview, review of the medical record Information and other facility documentation, it was Based on observation, interview, and determined that the facility failed to maintain a review of pertinent facility documents, it complete medical record for 1 of 28 sampled was determined that facility failed to residents (Resident #138). This deficient practice identify and eliminate known and

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY PLETED
		315514	B. WING	G			C 03/2023
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
EXCEL C	ARE AT EGG HARBC	R			6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234	4	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	۶IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 842	facility Admission F	he following: in the facility for contract the closed medical record the ace Sheet revealed that is admitted to the facility with	F	842	 foreseeable deficiency specifical ensuring maintaining of a comple medical record. The deficient prives was identified in 1 of 28 sampled residents, Resident #138. I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDE FOUND TO HAVE BEEN AFFEC THE DEFICIENT PRACTICE: Resident #138 is no longer in the as he/she was discharged home Resident was not adversely affect the deficient practice. 	NTS TED BY	
	Set (MDS), an asse care, dated A core as Interview for Menta indicating Resident Section I of the MD diagnosis of A review of a comp monitoring sheet in weight of A review of the nutr				 Medical Records was educated of 3/31/23 for the deficient practice. II. IDENTIFICATION OF RESIE WHO HAVE THE POTENTIAL TO AFFECTED BY THE SAME DEF PRACTICE: ¿ All residents in the facility has potential to be affected by the sad deficient practice. Medical Record checked like resident discharge to ensure compliance. III. MEASURES PUT INTO PLA SYSTEMIC CHANGES TO ENS THAT THE DEFICIENT PRACTICNOT RECUR: ¿ Medical Records was educa Administrator on the deficient practice on the deficient practice on the deficient practice of the completion of medical for the deficient practice. 	DENTS O BE TICIENT we the me rds records ACE OR URE CE WILL ted by actice. ee will or 3 quarters	

Facility ID: NJ01001

If continuation sheet Page 44 of 48

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMI	E SURVEY PLETED C
		315514	B. WING				03/2023
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	CARE AT EGG HARBC)R			818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	, regular ounces twice a day difficulty, feeds self (body mass index) feeding self at lunch chewing/swallowing had a EX. Order 26.(4) B normal. Resident st BID (twice a Resident had no qu to) diet. RD (register preferences to the I he/she was price Recommendations, ensure twice a day maintenance/gain. intake at meals. go body weight) with g WNL (within norma monitor, continue P A review of the care reflected under Pro nutrition problem at EX. Order 26.(4) B1 under Goals: I will maintain PO (of most meals with consumed thru nex CBW range as poss Interventions includ quarterly, monitor la weight as ordered, unless contraindica	r, thin liquids. EX. Order 26.(4) B1 /, no chewing or swallowing f, appetite good Exercise 20.(4) B1 EX. Order 26.(4) B1. Resident th. No reported problems g and no . Resident stated he/she at hospital but is now mostly tates at home he/she drinks a day) and eats 3 meals/day. uestion/concerns r/t (related ered dietician) to provide kitchen. Resident states (6)(9) a year ago but thinks for to hospitalization. Under continue to encourage good val to maintain CBW (current gradual EX. Order 26.(4) B1 to BMI al limits) for age, continue to POC (plan of care). e plan for Resident # 138 oblems: I have a potential nd at risk for EX. Order 26.(4) B1 The following was revealed	F 8	342	 IV. MONITORING OF CORRECTINACTIONS: The Administrator or designee with conduct audits of closed medical remonthly for 3 months, then quarterly quarters to ensure maintenance merecords in accordance with 483.70. results will be presented at the quar QAA Meeting. The QAPI Committe determine the need for further audit and/or action plans to ensure on-go compliance. V. COMPLETION DATE: May 10, 	will cords y for 3 edical Audit rterly ce will ts bing	

Facility ID: NJ01001

If continuation sheet Page 45 of 48

		AND HUMAN SERVICES	1			FORM	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	` ´COM	E SURVEY PLETED C
		315514	B. WING				03/2023
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL	CARE AT EGG HARBO)R		-	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	03/28/2023 at 10:50 #2) stated the facilit resident weight upor weights on Monday RN #2 went on to s at the desk and ond weight book on the book and when full papers and we give she keeps everythin is set up we can on into the electronic r During an interview time and date, Unit (UM/RN #1) said th do meal consumpti- resident gets their of living such as bathi and when the resid the chart with the d medical records co UM/RN#1 went on discharged to the h week to see if they put the ADL sheet i Medical Records co On 03/28/2023 at 1 requested from the and Vice President the weights from ac as well as the ADL DON and VPCS sa receptionist who wi referring to the wee unit. The DON wen	0 AM, Registered Nurse (RN ty weight policy is get a on admission and then weekly y, I think until they go home. ay they are written on a paper ce they are done, we have a unit. We keep the weight for the month we take out the e them to medical records, and ng. I think the way the system IV put in admission weights nedical record (EMR). with the surveyor at the same Manager/Registered Nurse the Certified Nursing Assistants on monitoring daily. Each own ADL (Activities of daily ng, eating, dressing) sheet ent leaves, we put it in front of ischarge paperwork and then mes and takes the chart. to say that if a resident is ospital, we will wait about are coming back and if no wet n the front of the chart and omes and gets the chart. 1:10 AM, the surveyor Director of Nursing (DON) of Clinical Services (VPCS) dmission and up to discharge, sheets for Resident #138. The	F	342			

Facility ID: NJ01001

If continuation sheet Page 46 of 48

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`́СОМ	E SURVEY PLETED
		315514	B. WING				C 03/2023
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	ARE AT EGG HARBC	R			8818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 842	Continued From pa (staff) obtain them.	ge 46	F٤	342			
	03/28/2023 at 12:59 Assistant #1 said w	with the surveyor on 9 PM, Certified Nursing the take resident weights at Ty Monday until discharged or family.					
	interview with the si couldn't find weight #138, as requested said, "Yeah, the me The weight sheet is part of the medical entered into the EM paper worksheets for dietician looks at th into the system." Th Resident #138 did b	8:46 AM, during a follow-up urveyor, the VPCS said she s or ADL sheets for Resident by the surveyor. The VPCS dical record is incomplete. a actually a work sheet and not record. The weights should be IR. The nursing team does or weights and then the e weights and enters them ne VPCS further stated that have a weight on admission ne but wasn't here that long.					
		9:49 AM, the VPCS came urveyor the only weight they					
	03/31/2023 at 01:42 "Absolutely, the me complete. When a p	with the surveyor on 2 PM, the VPCS stated, dical records should be patient is discharged the Medical Records. This s and weights."					
	dated 02/01/2023 rd section: It is the pol Medical Records in	y policy titled Medical Records evealed under the Intent icy of the facility to maintain accordance with State and . Under Procedure section 2:					

Facility ID: NJ01001

If continuation sheet Page 47 of 48

		AND HUMAN SERVICES				FORM	08/31/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		315514	B. WING				C 03/2023
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	CARE AT EGG HARBO	DR			818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	The facility will mai resident in accorda professional standa complete, accurate	ntain clinical records on each ince with accepted ards and practices that are ely documented, readily ically organized and include:	F	342			

Facility ID: NJ01001

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVISI	T
IDENTIFICATION NUMBER	A. Building				
315514 _{Y1}	B. Wing	Y	2	5/11/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
EXCEL CARE AT EGG HARBO	R	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		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix F	-0842	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. # 48	83.20(f)(5), 48 5)	3.70(i)(1)- Completed	Reg. #		Completed	Reg. #		Completed
	/	05/10/2023	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		
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 STATE AGE		REVIEWED BY (INITIALS)	DATE	SIGNATURE	OF SURVEYOR	I	DATE	
REVIEWED CMS RO) ВҮ	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWU 4/3/2023	P TO SURVE	COMPLETED ON			RRECTED DEFICIEN NCIES (CMS-2567)			s 🗆 no

PRINTED: 08/31/2023 FORM APPROVED

T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			DATE SURVEY
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	JOMPLETED
	01001	B. WING		C 04/03/2023
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	6818 DEL	ILAH ROAD		
	EGG HAF		ISHIP, NJ 08234	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
Initial Comments		S 000		
standards in the Ne Code, Chapter 8:39 Long Term Care Fa submit a plan of co completion date, fo that the plan is imp deficiencies may re accordance with the Jersey Admiistrative enforcement of Lice	ew Jersey Administrative 9, Standards for Licensure of acilities. The facility must rrection, including a r each deficiecncy and ensure lemented. Failure to correct esult in enforcement action in e provisisons of the New e Code, Title 8, Chapter 43E, ensure.	S 560		5/10/23
	NT is not met as evidenced			
Based on interview facility documentati facility failed to mai direct care staff to r the state of New Je 14-day shifts and d residents on 1 of 14 1. Findings include Reference: New Je (NJDOH) memo, da with N.J.S.A. (New	s and review of pertinent ion, it was determined that the ntain the required minimum resident ratios as mandated by ersey. This was evident for 9 of eficient in total staff for 4 overnight shifts. : ersey Department of Health ated 01/28/2021, "Compliance Jersey Statutes Annotated)		Care STATE S STAFFING RATIOS I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED B 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	3Y e
	OF CORRECTION PROVIDER OR SUPPLIER ARE AT EGG HARBO SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Initial Comments The facility was not standards in the Net Code, Chapter 8:38 Long Term Care Fa submit a plan of co completion date, fo that the plan is imp deficiencies may re accordance with th Jersey Admiistrativ enforcement of Lice 8:39-5.1(a) Mandat (a) The facility shall Federal, State, and regulations. This REQUIREMED by: C/O # NJ 0015358 Based on interview facility failed to maid direct care staff to re the state of New Jet 14-day shifts and d residents on 1 of 14 1. Findings include Reference: New Jet (NJDOH) memo, day with N.J.S.A. (New	OF CORRECTION IDENTIFICATION NUMBER: 01001 PROVIDER OR SUPPLIER STREET AD ARE AT EGG HARBOR 6818 DEL EGG HAR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure. 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)	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01001 B. WING	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: C NOVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE ARE AT EGG HARBOR 6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR US DIBENTIFYING INFORMATION) ID PRETIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-RECENCE DI STATE PROPORTING (EACH CORRECTIVE ACTION SHOULD BE CROSS-RECENCE DI STATE STATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-RECENCE DI STATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-RECENCE DI STATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-RECENCE DI STATE (COC) (COP (CORRECTIVE ACTION SHOULD BE CROSS-RECENCE DI STATE (COP TALE ACTIONS) (A) THE ACILITY AND ALL ACTIONS (A) THE ACILITY ACTIONS (A) THE ACILITY AND ALL ACTIONS (A) THE ACILITY ACTIONS (A) THE ACILITY ACTIONS (A) THE ACILITY AND ALL ACTIONS (A) THE ACILITY ACTIONS (A) THE ACILITY AND ALL ACTIONS (A) THE ACILITY AND A

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE 04/19/23

Electronically Signed

6899

If continuation sheet 1 of 8

New ler	sey Department of H	lealth			FORM A	PPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	
		01001	B. WING		04/03	8/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY.	STATE, ZIP CODE		
		6818 DEI	ILAH ROAD			
EXCEL C	CARE AT EGG HARBO)R		ISHIP, NJ 08234		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
S 560	Continued From pa	ige 1	S 560			
S 560	nursing homes," inc Governor signed in codified at N.J.S.A. established minimu nursing homes. The effective on 02/01/2 One Certified Nurse residents for the da One direct care sta residents for the ev fewer than half of a CNAs, and each dii signed in to work at nurse aide duties: a One direct care sta residents for the nig direct care staff me a CNA and perform As per the Nurse S the facility for the w 03/11/2023 and 03/ showed that the fac staffing for resident deficient in total sta overnight shifts as the -03/05/23 h on the day shift, rec -03/10/23 h on the day shift, rec -03/11/23 h on the day shift, rec -03/12/23 h on the day shift, rec -03/12/23 h on the day shift, rec -03/12/23 h	dicated the New Jersey to law P.L. 2020 c 112, 30:13-18 (the Act), which is staffing requirements in e following ratio(s) were 2021: e Aide (CNA) to every eight by shift. If member to every 10 rening shift, provided that no Il staff members shall be rect staff member shall be s a CNA and shall perform and If member to every 14 ght shift, provided that each mber shall sign in to work as a CNA duties. taffing Reports completed by reeks of 03/05/2023 to 12/2023 to 03/18/2023 cility was deficient in CNA is on 9 of 14-day shifts and diff or residents on 1 of 14 follows: ad 10 CNAs for 112 residents quired 14 CNAs. ad 12 CNAs for 110 residents quired 14 CNAs. ad 13 CNAs for 111 residents quired 14 CNAs. ad 10 CNAs for 111 residents quired 14 CNAs. ad 13 CNAs for 111 residents quired 14 CNAs. ad 13 CNAs for 111 residents quired 14 CNAs.	S 560	 Utilization of employment application websites; and fostering partnership recruitment and employment agent No residents have been adversely affected by the deficient practice. II. IDENTIFICATION OF RESIDE WHO HAVE THE POTENTIAL TO AFFECTED BY THE SAME DEFICE PRACTICE; All residents have the potentiat affected by this situation. III. SYSTEMIC CHANGES TO ENTHAT THE DEFICIENT PRACTIC NOT RECUR; Facility s Recruitment and Restrategies and Efforts have been i progress, which include but are not to the following: Offer Sign on bonuses to attrate or Recruitment bonus to encourar referrals from current staff Offer daily and weekend bonu attract overtime or PRN staff shifts or Regularly meet with Staff to be morale Conduct Staff Appreciation product staff Appreciation product staff Return and sin variou media platforms and employment application websites Flexible shifts and schedules or Increased wages to be well at state minimum Working with C.N.A. schools to new grads 	ps with ncies. ENTS BE CIENT al to be NSURE E DOES etention n ot limited act staff age uses to soost ograms ention is social	
	on the day shift, red -03/15/23 h	ad 13 CNAs for 111 residents		o Contract with staffing agencies	3	

PRINTED: 08/31/2023 FORM APPROVED

	sey Department of H	lealth (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION (X	3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	
		01001	B. WING		C 04/03/2023	;
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EXCEL C	CARE AT EGG HARBO)R	ILAH ROAD	ISHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		ETE
S 560	on the day shift, rec -03/17/23 h on the day shift, rec -03/18/23 h on the day shift, rec -03/18/23 h residents on the ov staff. During an interview 03/30/2023 at 10:30 said that yes, she is to resident ratio ma facility was meeting she replied, "Yes, w Sometimes we hav them." During an interview 03/31/2023 at 1:30 Home Administrato of the staffing ratio surveyor. The LNH the time we are me 8:39-19.5(a) Manda Sanitation a) The facility shall	quired 14 CNAs. ad 12 CNAs for 109 residents quired 14 CNAs. ad 11 CNAs for 107 residents quired 13 CNAs. ad 7 total staff for 107 ernight shift, required 8 total with the surveyor on 9 AM, the Staffing Coordinator s aware of the required CNA andates. When asked if the g the minimum requirements we meet those requirements. e callouts, but we cover with the surveyor on PM, the Licensed Nursing r (LNHA) said yes, I am aware mandate, when asked by the A went on to say that most of	S 560 S 1405	 IV. MONITORING OF CORRECTIV ACTIONS The Director of Nursing will provive weekly reports to the Administrator regarding all efforts made to try to convit the State s Staffing Ratios. Rewill be submitted to the Corporate Dirof Human Resources/Payroll. Corporate Director of Human Resources/Payroll will submit monthin reports to the QAPI (Quality Assuran and Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, documenting status of all recruitment and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, document and performance Improvement) Committee X 6 months, document and performance Improvement) Committee X 6 months, document and retention efforts. The QAPI (Quality Assurance Performance Improvement) Committee X 6 months, document and performance Improvement) Committee X 6 months, document and performance Improvement) Committee X 6 months, document and performance Improvement) Commit X will determine the need for further and plans. 	de mply ports rector y ce and ee	23
	examination perform advanced practice physician assistant first day of employer the new employee assessment by a re upon employment, practice nurse's examples	med by a physician or nurse, or New Jersey licensed , within two weeks prior to the nent or upon employment. If				

POXK11

If continuation sheet 3 of 8

PRINTED: 08/31/2023 FORM APPROVED

	rsey Department of H NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		OATE SURVEY OMPLETED
		01001	B. WING		C 04/03/2023
	PROVIDER OR SUPPLIER	6818 DEL	ILAH ROAD	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
S1405	The facility shall es	ge 3 tablish criteria for determining f physical examinations for	S1405		
	by: Based on interview employee files, it w failed to ensure tha employees had con received an examin Advanced Practice Physician Assistant employment or upo This deficient practif following: On 03/27/2023 at 1 reviewed the employ recently hired employ Employee # 1 was physical was compl employee had the p prior to hire.	npleted a health history and lation by a Physician, an Nurse, or a Licensed within two weeks prior to n employment. tice was evidenced by the 1:00 AM, the surveyor byee files of five random and oyees. hired on the surveyor hired on the surveyor by a surv		 S1405: Mandatory Infection Control and Sanitation Based on observation, interview, and review of pertinent facility documents, i was determined that facility failed to identify and eliminate known and foreseeable deficiency specifically by n 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 F THE DEFICIENT PRACTICE: All residents have the potential to be affected. Employee #1 and Employee 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 	ot 3Y #2

	Sey Department of H IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMPI	
		01001	B. WING		C 04/0	; 3/2023
AME OF I	PROVIDER OR SUPPLIER	STREET AL		STATE, ZIP CODE		0/2020
XCEL C	CARE AT EGG HARBO	JR States and Sta	LILAH ROAD RBOR TOWN	ISHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
	03/27/2023 at 12:4 Director (HRD) was employee required said if the employe six months to a yea physical through th The HRD said that 2-week window to their date of hire. The HRD confirme physical on	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 4 uring an interview with the surveyor on b/27/2023 at 12:48 PM, the Human Resources rector (HRD) was asked when are new inployee required to get a physical? The HRD id if the employee hasn't had one in the past k months to a year, they will schedule a hysical through the facility or their physician. The HRD said that new employees are given a week window to get a physical completed from eir date of hire. The HRD confirmed that employee #1 had their hysical on Confirmed that employee #2 had eir physical Confirmed that employee #2 had eir physical Confirmed that on the pasid the hysicals were not within 2 weeks of their date of		 WHO HAVE THE POTENTIA AFFECTED BY THE SAME PRACTICE: All residents in the faciliti potential to be affected by the deficient practice. X. MEASURES PUT INTO SYSTEMIC CHANGES TO B THAT THE DEFICIENT PRANOT RECUR: On March 31, 2023, Administer educated HRD on NJ 8:39-1 A new hire check list was determined completeness of physical externations of the stabilish criteria for determined completeness of physical externation of the stabilish criteria for determined completeness of physical externational stabilish criteria for determined completeness of physical externational stabilish criteria for determined completeness of physical externational stabilish criteria for determined and the stabilish criteria f	DEFICIENT ty have the le same PLACE OR ENSURE ACTICE WILL strator 9.59(a) eveloped to ning the timely caminations rting, the employee ely	
				XI. MONITORING OF COR ACTIONS: The administrator will audit t files weekly for 4 weeks and for 3 months to ensure timel completeness of physical ex The results of the audits will during the QAPI Committee. The QAPI Committee will ma recommendations based up of the audits. Upon attaining consistent co QAPI committee will determic continuation of the audits.	RECTIVE the new hire then monthly y aminations. be reviewed ake on the results	

PRINTED: 08/31/2023 FORM APPROVED

New Jer	sey Department of I	lealth			RM APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY
			A. BUILDING		
		01001	B. WING		C 04/03/2023
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
	ARE AT EGG HARBO				
		ATEMENT OF DEFICIENCIES		SHIP, NJ 08234 PROVIDER'S PLAN OF CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
S1410	Continued From pa	age 5	S1410		
S1410	8:39-19.5(b)(1) Ma Sanitation	ndatory Infection Control and	S1410		5/10/23
	the medical staff er employment shall r tuberculin skin test purified protein der shall be employees two-step Mantoux s millimeters of indur employees with a c skin test result (10 induration), employ appropriate medical when medically con Mantoux tuberculin new employees sh 1. If the first ste skin test result is le induration, the	oyee, including members of mployed by the facility, upon receive a two-step Mantoux with five tuberculin units of ivative. The only exceptions is with documented negative skin test results (zero to nine ration) within the last year, documented positive Mantoux or more millimeters of vees who have received al treatment for tuberculosis, or intraindicated. Results of the a skin tests administered to all be acted upon as follows: ep of the Mantoux tuberculin ess than 10 millimeters of second step of the two-step be administered one to three			
	by: Based on interview it was determined t that 1 of 5 newly hi Mantoux tuberculin person has been in hire as required. Th	NT is not met as evidenced and review of facility records, that the facility failed to ensure red employees received the test (a test to check if a infected with TB bacteria) upon his deficient practice was new employee files reviewed		S1410 Mandatory Infection Control and Sanitation Based on observation, interview, and review of pertinent facility documents, i was determined that facility failed to identify and eliminate known and	t

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		01001	B. WING		C 04/03/2023	
EXCEL	PROVIDER OR SUPPLIER	DR 6818 DEI EGG HAI	LILAH ROAD	ISHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLE	
S1410	and is evidenced b On 03/27/2023 at 1 employee files reve Employee #1 had a During an interview 03/27/2023 at 12:4 Director (HRD) was employees required replied, new emplo upon hire via the fa completed during o	y the following: 11:00 AM, a review of new ealed the following: a Mantoux on 10/10/2018. w with the surveyor on 8 PM, the Human Resources s asked when are new d to get a Mantoux. The HRD byees should have Mantoux acility and the 1st step prientation. d that employee #1 had their	S1410	foreseeable deficiency spee ensuring that 1 of 5 newly h employees received the Ma tuberculin test upon hir. T practice was identified in 1 employee files reviewed. What corrective action will h accomplished for those res by the deficient practice? No residents were identified have the potential to be affe Employee #1 will have a net test on 4/27/23. In addition, employee health files were compliance to ensure all en- twostep Mantoux test and of complete. How will you identify other in having the potential to be a deficient practice and what action will be taken? All residents have the poter affected. Employee #1 will Mantoux test on 4/27/23. In current employee health file audited for compliance to e employees had a two step and or x ray complete. What measures will be put what systemic changes have ensure the deficient practic reoccur?	hired antoux he deficient of 5 new be idents affected d. All residents ected. We Mantoux all current audited for nployees had a or x ray residents ffected by the corrective hial to be have a new addition, all es were nsure all Mantoux test into place or ye you made to	

PRINTED: 08/31/2023 FORM APPROVED

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 01001			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		01001	B. WING			3/2023
JAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
XCEL	CARE AT EGG HARBO)R	LILAH ROAD	ISHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
\$1410	Continued From pa	age 7	S1410	On March 31, 2023, Adminis educated HRD on NJ 8:39-1 A new hire check list was de establish criteria for determir completeness of a two-step and/or X-ray (as applicable) employees. Prior to a new employee stat Administrator will sign off on personnel file to include time completeness of a two-step and/or X-ray. How will the corrective action monitored to ensure the defi- will not reoccur? (QA Progra The administrator will audit t files weekly for 4 weeks and for 3 months to ensure timely completeness of a two-step and/or X-ray. The results of the audits will during the QAPI Committee. The QAPI Committee will ma recommendations based up of the audits. Upon attaining consistent co QAPI committee will determi continuation of the audits. Completion Date: 5/10/23	9.59(b) veloped to ning the timely Mantoux test for ting, the employee ly Mantoux test ns be cient practice ams). he new hire then monthly Mantoux test be reviewed ake on the results mpliance, the	

PRINTED:	08/31/2023
FORM	APPROVED
OMB NO	0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 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 222 K 222 Egress Doors 5/10/23 SS=E 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 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

04/19/2023

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **01** 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 222 Continued From page 1 K 222 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 2 of 15

		AND HUMAN SERVICES	_			FORM	08/31/2023 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
		315514	B. WING	i		04/	03/2023
NAME OF	PROVIDER OR SUPPLIER	I		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL (CARE AT EGG HARBO	DR		-	818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 222	 18.2.2.2.4, 19.2.2.2 This REQUIREMENER by: Based on observation provided document 03/27/2023, it was failed to provide 1 of the means of egress of all obstructions of use in the case of faccordance with the 2012 Edition, Sectionand 19.2.2.2.6. Findings include: On 03/24/2023 (data survey entrance at request was made and Maintenance A copy of the facility I various rooms and facility. A review of the faci that there are nine doors (illuminated of Residents to use of facility. Starting at approxim 03/24/2023 and compresence of the facility is purify the following: 	A NT is not met as evidenced tion and review of facility tation on 03/24/2023 and determined that the facility of 9 exit discharge doors in as readily accessible and free or impediments to full instant ire or other emergencies in e requirements of NFPA 101, on 19.2.2.2.5.1, 19.2.2.2.5.2 y one of survey) during the approximately 08:35 AM, a to the Administrator (Admin) Assistant (MA) to provide a ay-out which identifies the smoke compartments in the lity provided lay-out identified (9) designated exit discharge exit signs above doors) for uring an evacuation in the mately 09:03 AM on ntinued on 03/27/2023, in the cility's Admin and MA a tour of		222	 8) K222: S/S = E Egress Doors Based on observation, interview, and review of pertinent facility document was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically a thumb turn security locking device fastening device on the front main a doors. The deficient practice was identified in 1 of 1 sliding door location VII. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTION ACCOMPLISHED FOR RESIDENT FOUND TO HAVE BEEN AFFECTION THE DEFICIENT PRACTICE: ¿ The Maintenance Director immediately disabled the lock and of to make it permanently nonfunction No residents were adversely affect the deficient practice. VIII.IDENTIFICATION OF RESIDE WHO HAVE THE POTENTIAL TO AFFECTED BY THE SAME DEFICE PRACTICE: ¿ All residents in the facility have potential to be affected by the same deficient practice. 	having e and sliding tions. TS ED BY device al. ed by NTS BE HENT the e	

Facility ID: NJ01001

If continuation sheet Page 3 of 15

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-0391

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

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 093				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION 01		E SURVEY PLETED
		315514	B. WING			04/	03/2023
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	EXCEL CARE AT EGG HARBOR				818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 222	automatic sliding ex set of doors) reveal egress side. The th device on the door of the exit. The Admin. and MA time of observation On 03/27/2023 duri approximately 01:1	ved the main entrance set of kit discharge doors (external led thumb turn lock on the umb turn lock and fastening could restrict emergency use A confirmed the findings at the s. ing the survey exit at 5 PM, the surveyor informed f the Life Safety Code	К 2	222	 ¿ The Maintenance Director was educated by Administrator on K22 definition and details. ¿ Director of Maintenance or de will include observation of the outs smoking areas to ensure safety ar cleanliness when conducting daily environmental rounds. ¿ The Director of Maintenance of all sliding doors to ensure deficient practice was corrected. XIII.MONITORING OF CORRECT ACTIONS: ¿ The administrator or Designed conduct Observation Rounds of al doors weekly x 4 weeks, then mor thereafter x 2 months, to ensure the sliding doors always remain unloc Audit results will be presented at t quarterly QAA Meeting. The QAP Committee will determine the need further audits and/or action plans to ensure on-going compliance. 	2 signee side nd checked t TVE will I sliding nthly nat the ked. he I d for	
K 271 SS=E	Discharge from Exi CFR(s): NFPA 101	ts	K 2	271	XIV. COMPLETION DATE: 5/*	10/ 2023	5/10/23
	7.7, provides a leve provisions of 7.1.7 elevation and shall obstructions. Additi be a hard packed a 18.2.7, 19.2.7	ts ranged in accordance with el walking surface meeting the with respect to changes in be maintained free of onally, the exit discharge shall ill-weather travel surface. NT is not met as evidenced					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 4 of 15

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY PLETED
		BERTHIO, THOR HOMBER.	A. BUILDIN	NG 01		
		315514	B. WING _			03/2023
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
EXCEL	CARE AT EGG HARBO	DR		6818 DELILAH ROAD EGG HARBOR TOWNSHIP,	NJ 08234	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIC DATE
K 271	Continued From pa	ige 4	K 27	71		
	 provided document 03/27/2023 in the p management, it wa failed to provide a s at 1 of 9 designated serve residents in a This deficient pract following: On 03/24/2023 (day survey entrance at request was made and Maintenance A copy of the facility I various rooms and facility. A review of the faci that there are nine doors (illuminated e Residents use durin facility. During the building Admin and MA the following, 1. On 03/27/2023 a observed that the a designated exit dise 	tions and review of facility tation on 03/24/2023 and presence of facility s determined that the facility suitable surface for evacuation d exit discharges that would an evacuation route. ice was evidenced by the y one of survey) during the approximately 08:35 AM, a to the Administrator (Admin) Assistant (MA) to provide a ay-out which identifies the smoke compartments in the lity provided lay-out identified (9) designated exit discharge exit signs above doors) for ng an evacuation in the tour in the presence of the surveyor observed the it 9:40 AM, the surveyor activity room had one charge door and the dining gnated exit discharge door		K 271: S/S = E Discharge from Exits Based on observation, review of pertinent facil was determined that fa- identify and eliminate k foreseeable accident has resident's environment providing the proper lev suitable surface emerg from the fenced in resident patio gate, to the fire ro practice was identified designated exit dischar serve residents in an ev IX. CORRECTIVE ACT ACCOMPLISHED FOR FOUND TO HAVE BEE THE DEFICIENT PRAC ¿ The Maintenance E schedule a company to concrete the designate- path. No residents were advec the deficient practice. X. IDENTIFICATION O WHO HAVE THE POTE AFFECTED BY THE SA PRACTICE: ¿ All residents in the potential to be affected deficient practice.	ity documents, it cility failed to nown and azard in the specifically by not veled concrete ency path located dent smoking are ad. The deficient in 1 of 9 ges that would vacuation route. TIONS RESIDENTS ENAFFECTED BY CTICE: Director called to come quote and d exit discharge ersely affected by DF RESIDENTS ENTIAL TO BE AME DEFICIENT facility have the	

Facility ID: NJ01001

If continuation sheet Page 5 of 15

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **01** 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 271 Continued From page 5 K 271 grass path to the fire road. NOT RECUR: The Maintenance Director was ż. The Admin and MA confirmed the finding at the educated by Administrator on k271 time of observation. definition and details. Director of Maintenance or designee ż On 03/27/2023 during the survey exit at will include observation of the designated approximately 01:15 PM, the surveyor informed exit surfaces for evacuation ensure safety the Administrator of the Life Safety Code and compliance when conducting daily deficiency. environmental rounds. The Director of Maintenance checked ż. Life Safety Code 101 - 18.2.7 all designated exit discharge surfaces to NJAC 8:39-31.2(e) ensure no other deficient practices were present. MONITORING OF CORRECTIVE XVI. 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 guarterly 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 K 281 Illumination of Means of Egress 5/10/23 SS=E 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

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

If continuation sheet Page 6 of 15

CENTE		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILE		E CONSTRUCTION	=ORM / <u>B NO.</u> <3) date	08/31/2023 APPROVED 0938-0391 SURVEY PLETED
		315514	B. WING	i		04/0	3/2023
	PROVIDER OR SUPPLIER	DR		68	TREET ADDRESS, CITY, STATE, ZIP CODE 818 DELILAH ROAD GG HARBOR TOWNSHIP, NJ 08234	04/0	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 281	intervention. 18.2.8, 19.2.8 This REQUIREMEN by: Based on observations 03/27/2023, it was failed to ensure cordination designated exit disc arranged so that the unit did not result in than 0.2 ft-candle in accordance with NH (2021 edition) Sect 7.8.1.4 The evidence inclustion On 03/24/2023 (data survey entrance at request was made and Maintenance A copy of the facility I various rooms and facility. A review of the facility I various rooms and facility. Starting at approxin 03/24/2023 and con- presence of the facility.	NT is not met as evidenced tions on 03/24/2023 and determined that the facility ntinuous illumination for 2 of 9 charges were provided and e failure of any single lighting n an illumination level of less n any designated area in PA 101 Life Safety Code ions 7.8.1.1, 7.8.1.2 and des the following, y one of survey) during the approximately 08:35 AM, a to the Administrator (Admin) Assistant (MA) to provide a ay-out which identifies the smoke compartments in the lity provided lay-out identified (9) designated exit discharge exit signs above doors) for uring an evacuation in the nately 09:03 AM on ntinued on 03/27/2023, in the iility's Admin and MA a tour of	K	281	K 281: S/S = E Illumination of Means of Egress Based on observation, interview, and review of pertinent facility documents was determined that facility failed to identify and eliminate known and foreseeable accident hazard in the resident's environment specifically by providing continuous illumination for designated exit discharges. The defice practice was identified in 2 of 9 designated exit discharges. XI. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED THE DEFICIENT PRACTICE: ¿ The Maintenance Director installed proper continuous lighting in accorda with NFPA 101 life safety code Section 7.8.1.1, 7.8.1.2 and 7.8.1.4 in 2 of 9 deficient locations. No residents were adversely affected the deficient practice. XII. IDENTIFICATION OF RESIDENT WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIE PRACTICE: ¿ All residents in the facility have th potential to be affected by the same deficient practice. XVIII. MEASURES PUT INTO PLA	s, it y not cient S D BY ed ance ons d by TS E TS E TNT he	

Facility ID: NJ01001

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-0391

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

CENTER		& MEDICAID SERVICES				OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		e construction 01	(-)	E SURVEY PLETED
		315514	B. WING			04/0	03/2023
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EXCEL C	EXCEL CARE AT EGG HARBOR				818 DELILAH ROAD GG 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 PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 281	observed outside ti door, next to reside light bulb fixture. 2. At approximate observed outside ti resident room fixture. The Admin and MA time of observation On 03/27/2023 dur approximately 01:1	y 09:06 AM, the surveyor he stairwell exit discharge ent room, had a single by 09:37 AM, the surveyor he exit discharge door, next to had a single light bulb a confirmed the finding at the h. ing the survey exit at 5 PM, the surveyor informed f the Life Safety Code	К 2	81	OR SYSTEMIC CHANGES TO EN THAT THE DEFICIENT PRACTICE NOT RECUR: The Director of Maintenance check designated exit discharge locations ensure proper continuous illuminat was installed and working properly The Maintenance Director was edu by Administrator on K281 definition details. Director of Maintenance or designat discharges ensure safety and com when conducting weekly environm rounds. XIX. MONITORING OF CORREN ACTIONS: ¿ The Maintenance Director or designee will conduct Observation Rounds of all designated discharge weekly x 4 weeks, then monthly the x 2 months, to ensure that the cont lighting need to meet code is in pla Audit results will be presented at th quarterly QAA Meeting. The QAPI Committee will determine the need further audits and/or action plans to ensure on-going compliance.	E WILL ked all s to ion ucated n and ee will ted exit pliance ental ECTIVE e exits ereafter tinuous ice. ne I for	
K 291 SS=D	Emergency Lightin CFR(s): NFPA 101		К 2	91	XX. COMPLETION DATE: 5/10/ 2	023	5/10/23
		g g of at least 1-1/2-hour duration itically in accordance with 7.9.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: NJ01001

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **01** 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 291 Continued From page 8 K 291 This REQUIREMENT is not met as evidenced by: K 291: S/S = D Based on observation and interview on 03/24/2023, in the presence of facility **Emergency Lighting** management, it was determined that the facility Based on observation, interview, and failed to: Provide a battery backup emergency review of pertinent facility documents, it light above one (1) of two (2) emergency was determined that facility failed to generator's transfer switches, independent of the identify and eliminate known and building's electrical system and emergency foreseeable accident hazard in the generator, in accordance with NFPA 101:2012 resident's environment specifically by not 7.9, 19.2.9.1. providing a battery backup emergency light above 1 of 2 emergency generator's This deficient practice was evidenced by the transfer switches, independent of the building's electrical system and following: emergency generator. The deficient On 03/24/2023 (day one of survey) during the practice was identified in 1 of 2 survey entrance at approximately 08:35 AM. a emergency generator locations. request was made to the Administrator (Admin) and Maintenance Assistant (MA) if the facility had XIII.CORRECTIVE ACTIONS an Emergency Generator. The Admin told the ACCOMPLISHED FOR RESIDENTS surveyor, yes we a Diesel Generator. FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Starting at approximately 09:03 AM on The Maintenance Director installed a 03/24/2023, in the presence of the facility's proper battery backup emergency light Admin. and MA, a tour of the facility was above the 1 emergency generator's conducted. During the tour the surveyor transfer switch in accordance with NFPA observed the following, 101:2012-7.9,19.2.9.1 in 1 of 2 deficient locations. No residents were adversely affected by At approximately 09:18 AM an inspection in the basement level electrical area identified two (2) the deficient practice. emergency generator transfer switches. The surveyor observed no evidence of a battery back XIV. **IDENTIFICATION OF** up emergency light for the generators "Life **RESIDENTS WHO HAVE THE** Safety Branch" transfer switch. POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The Admin and MA confirmed the finding at the All residents in the facility have the ż. time of observation. potential to be affected by the same deficient practice.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 9 of 15

PRINTED: 08/31/2023 FORM APPROVED OMB NO. 0938-0391

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

CENTER	KS FUR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		E SURVEY PLETED
		315514	B. WING		04/	03/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
EXCEL C	EXCEL CARE AT EGG HARBOR			6818 DELILAH ROAD EGG HARBOR TOWNSHIP, N	J 08234	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
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 2	 91 XXI. MEASURES PUT OR SYSTEMIC CHANGE THAT THE DEFICIENT P NOT RECUR: The Maintenance Direducated by the Administ definition and details. Director of Maintenar will include observation or emergency generator translocations to ensure safety when conducting weekly rounds. The Director of Maintenar checked emergency generator so ensure safety when conducting weekly rounds. The Director of Maintenar checked emergency generator and checked emergency generator and working properly. 	ES TO ENSURE RACTICE WILL ector was rator on k291 ace or designee f the designated asfer switch and compliance environmental atenance erator transfer e proper battery	
				XXII. MONITORING O ACTIONS: ; The Maintenance Dir designee will conduct Ob Rounds of all designated generator transfer switch x 4 weeks, then monthly t months, to ensure that the lighting need to meet cod Audit results will be prese quarterly QAA Meeting. T Committee will determine further audits and/or action ensure on-going compliant	ector or servation emergency locations weekly hereafter x 2 e continuous e is in place. ented at the The QAPI the need for on plans to nce.	
K 521 SS=E	HVAC CFR(s): NFPA 101		K 5	21 XXIII. COMPLETION D	ATE: 5/10/ 2023	5/10/23

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G 01	OMB NO. 0938 (X3) DATE SURV COMPLETED	ΈY
		315514	B. WING		04/03/20	23
IAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODI 6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08:	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	CTION () OULD BE COMP	X5) 'LETIO ATE
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			1 K 521: S/S = E HVAC		
	failed to ensure that systems were being 10 Resident bathro the National Fire Pl 90A. This deficient pract following: On 03/24/2023 (dat survey entrance at	s determined that the facility s determined that the facility t the facility's ventilation g properly maintained for 5 of om exhaust systems as per rotection Association (NFPA) ice was evidenced by the y one of survey) during the approximately 08:35 AM, a to the Administrator (Admin)		Based on observation, intervie review of pertinent facility doct was determined that facility fa identify and eliminate known a foreseeable accident hazard in resident's environment specifi ensuring that the facility's vent systems were being properly r for 5 of 10 Resident bathroom systems as per NFPA 90A.The practice was identified in 5 of bathroom locations.	uments, it iled to ind in the cally by not tilation maintained exhaust e deficient	
	and Maintenance A copy of the facility I various rooms and facility. A review of the faci that the facility is a	Assistant (MA) to provide a ay-out which identifies the smoke compartments in the lity provided lay-out identified two-story building with 66 rooms and various common		XV. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESII FOUND TO HAVE BEEN AFF THE DEFICIENT PRACTICE: ¿ The Maintenance Director repair of facility's ventilation sy per NFPA 90A. No residents were adversely a the deficient practice.	ECTED BY ensured /stems as	

Facility ID: NJ01001

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **01** 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 521 Continued From page 11 K 521 Starting at approximately 09:03 AM on **IDENTIFICATION OF** XVI. 03/24/2023 and continued on 03/27/2023, in the **RESIDENTS WHO HAVE THE** presence of the facility's Admin and MA, a tour of POTENTIAL TO BE AFFECTED BY THE the building was performed. During the two day SAME DEFICIENT PRACTICE: tour, the surveyor inspected and tested ten (10) All residents in the facility have the ż. Resident sleeping rooms bathroom exhaust potential to be affected by the same deficient practice. systems. XXIV. MEASURES PUT INTO PLACE This inspection identified when the bathroom OR SYSTEMIC CHANGES TO ENSURE exhaust systems were tested (by placing a piece THAT THE DEFICIENT PRACTICE WILL of single ply tissue paper across the grills to NOT RECUR: confirm ventilation is present), the exhaust did The Maintenance Director was ż not function properly in 5 of 10 resident educated by Administrator on K521 bathrooms in the following locations: definition and details. Director of Maintenance or designee ż. On 03/24/2023. will include observation of resident 1. At approximately 09:58 AM, inside Resident bathroom exhaust systems to ensure bathroom, when tested the exhaust room safety and proper performance of resident system did not function properly. bathroom exhaust systems when At that time, the surveyor informed the Admin and conducting daily environmental rounds. MA that the exhaust system did not function The Director of Maintenance checked Ż. properly. This bathroom had no window with an all other Resident bathroom exhaust area that would open. This bathroom would rely systems to ensure functionality as per on mechanical ventilation. NFPA 90A. 2. At approximately 10:20 AM, inside Resident room bathroom, when tested the exhaust XXV. MONITORING OF CORRECTIVE system did not function properly. This bathroom ACTIONS: had no window with an area that would open. The Maintenance Director or This bathroom would rely on mechanical designee will conduct Observation Rounds of 10 Resident bathroom exhaust ventilation. systems weekly x 4 weeks, then monthly thereafter x 2 months, to ensure that On 03/27/2023. 3. At approximately 09:31 AM, inside Resident resident bathroom exhaust systems meet room # bathroom, when tested the exhaust the NFPA 90A requirement. system did not function properly. This bathroom Audit results will be presented at the had no window with an area that would open. quarterly QAA Meeting. The QAPI This bathroom would rely on mechanical Committee will determine the need for

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 12 of 15

PRINTED: 08/31/2023 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **01** 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 521 Continued From page 12 K 521 ventilation. further audits and/or action plans to ensure on-going compliance. 4. At approximately 09:53 AM, inside Resident XXVI. COMPLETION DATE: 5/10/ 2023 room 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 # 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. **NFPA 90A.** NJAC 8:39-31.2 (e). K 911 Electrical Systems - Other K 911 5/10/23 SS=D 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 13 of 15

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		E SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING 01	COM	PLETED	
		315514	B. WING		04/	03/2023	
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, 2	ZIP CODE		
EXCEL CARE AT EGG HARBOR				6818 DELILAH ROAD EGG HARBOR TOWNSHIP,	NJ 08234		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
K 911	Continued From pa	ige 13	K 9	911			
	03/27/2023, in the p management, it wa failed to ensure tha located next to a wa was equipped with Ground-Fault Circu protection. This deficient pract following: On 03/24/2023 (day survey entrance at request was made and Maintenance A copy of the facility I various rooms and facility. A review of the faci that the facility is a Resident sleeping n areas. Starting at approxin 03/24/2023 and con presence of the faci the building was per tour, the surveyor of four (24) electrical of in wet locations with the outlets. The sur-	s determined that the facility t 1 of 24 electrical outlets ater source (with-in 6 feet) safe and secured it Interrupter (GFCI) ice was evidenced by the y one of survey) during the approximately 08:35 AM, a to the Administrator (Admin) Assistant (MA) to provide a ay-out which identifies the smoke compartments in the lity provided lay-out identified two-story building with 66 rooms and various common mately 09:03 AM on ntinued on 03/27/2023, in the cility's Admin and MA, a tour of erformed. During the two day observed and tested twenty outlets (with-in 6 feet of a sink) h a GFCI tester to de-energize rveyor observed the following: at approximately 09:55 AM,		K 911: S/S = D Electrical Systems- othe 101 Based on observation, i review of pertinent facili was determined that fac identify and eliminate ku foreseeable accident ha resident's environment ensuring that 1 of 24 ele located next to a water feet) Resident bathroom as per NFPA 90A.The d was identified in 1 of 24 located next to a water feet). XVII. CORRECTIVE ACCOMPLISHED FOR FOUND TO HAVE BEE THE DEFICIENT PRAC ¿ The Maintenance D replacement of GFCI in bathroom. No residents were advec the deficient practice. XVIII. IDENTIFICATIO RESIDENTS WHO HAM POTENTIAL TO BE AF SAME DEFICIENT PRAC ¿ All residents in the potential to be affected deficient practice.	interview, and ity documents, it cility failed to nown and azard in the specifically by not ectrical outlets source (within 6 n exhaust systems leficient practice electrical outlets source (within 6 ACTIONS RESIDENTS NAFFECTED BY CTICE: Director ensured Resident ersely affected by ON OF /E THE FECTED BY THE ACTICE: facility have the by the same		
	the surveyor observe	ved inside Resident room e (1) GFCI electrical outlet.		XXVII. MEASURES PI OR SYSTEMIC CHANC			

Facility ID: NJ01001

If continuation sheet Page 14 of 15

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING **01** 315514 B. WING 04/03/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6818 DELILAH ROAD **EXCEL CARE AT EGG HARBOR** EGG HARBOR TOWNSHIP, NJ 08234 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) K 911 Continued From page 14 K 911 When the surveyor tested the GFCI electrical THAT THE DEFICIENT PRACTICE WILL outlet with a GFCI tester to de-energize, the NOT RECUR: GFCI electrical outlet did de-energize as required The Maintenance Director was Ś by code. When the surveyor pushed the re-set educated by Administrator on K911 button, the GFCI electrical outlet had no electric definition and details. Director of Maintenance or designee power. ż. will include observation of resident GFCI At that time the surveyor requested the MA to outlets to ensure safety and proper push the re-set button to the GFCI outlet. The performance of resident bathroom GFCI GFCI outlet could not restore electric power. outlets when conducting daily environmental rounds. The Admin and MA confirmed the finding at the The Director of Maintenance ż time of observation. checked all other Resident bathroom GFCI outlets to ensure safety and On 03/27/2023 during the survey exit at compliance with NFPA 101. approximately 01:15 PM, the surveyor informed the Administrator of the Life Safety Code XXVIII. MONITORING OF CORRECTIVE deficiency. ACTIONS: NJAC 8:39 -31.2 (e) The Maintenance Director or NFPA 99: -6.3.2.1, NFPA 70: -210.8 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

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: NJ01001

If continuation sheet Page 15 of 15

PRINTED: 08/31/2023

FORM APPROVED

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - EGG HARBOR HCC		DATE	OF REVIS	SIT	
	B. Wing	Y2	5/11/2	2023	Y3	
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
EXCEL CARE AT EGG HARBO	R	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).

ITE Y4		DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
		15	14			15	14			15
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	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 1	01	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. # LSC		Completed	Reg. # LSC			Completed	Reg. # LSC			Completed
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			
REVIEW STATE A		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 4/3/2023			ANY UNCORRE					s 🗆 no		