STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315317	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at the Pines	29 North Vermont Ave Atlantic City, NJ 08401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interviews, review of facility policy, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy to a.) complete reference checks on employees before their start date and b.) complete criminal background checks prior to their start date of employment. This deficient practice was identified for 12 of 50 employee files reviewed (Employee #2, #3, #5, #6, #9, #31, #42, #45 and #50), and was evidenced by the following:A review of the facility's Employee Health Screening, Background Checks, and License Verification policy dated 5/1/2025 included, The facility shall ensure that all employees, contractors, and licensed practitioners are qualified, competent, and medically fit for duty, and do not pose a risk to residents, in compliance with Federal and New Jersey regulations. No employees shall begin work without completion of required pre-employment screening, background checks, health clearance, and license verification (if applicable).Prior to hire, the facility shall complete: Criminal background check in accordance with NJ law abuse registry checks, .Verification that the individual: Has no history of abuse, neglect, or exploitation. Has not been excluded from Federal programs.Documentation, Background check clearance maintained in personnel file.The surveyor reviewed fifty employee files for newly hired staff since the last standard survey on 11/19/2024, which revealed the following screening documents were incomplete:Employee #2, a Certified Nursing Aide (CNA), was hired 8/15/2025. There were no reference checks.Employee #3, a Registered Nurse (RN), was hired on 1/19/2025. There were no reference checks and the criminal background check was done on 1/22/2025, after the hire date.Employee #5, a Licensed Practical Nurse (LPN), was hired on 10/27/2025 the criminal background check was completed on 8/21/2025, over two months prior to the hire date.Employee #6, an LPN, was hired 3/2/2025. There were no reference checks, and the criminal background check was done on 3/5/2025, after the hire date.Employee #9, a Licensed Nursing Home Administrator (LNHA), was rehired 1/19/2025. There were no reference checks or criminal background checks.Employee #31, a Maintenance Assistant, was hired 11/9/2025. There was no criminal background check.Employee #42, a Staffing Coordinator, was hired 2/11/2026. There were no reference checks.Employee #45, an Assistant Administrator, was hired on 1/5/2025. The criminal background check was done on 1/13/2025, after the hire date.Employee #50, a Social Worker Assistant, was hired on 6/9/2025. The criminal background check was done on 6/16/2025, after the hire date.On 4/2/2026 at 12:00 PM, the surveyor interviewed the LNHA who stated that the facility did not have a Human Resources Director and referred the surveyor to the [NAME] President of Human Resources (VPHR).On 4/2/2026 at 12:30 PM, the surveyor interviewed the VPHR who stated that the LNHA had been overseeing, interviewing, onboarding and hiring and she was only assisting with payroll for now. She added that she and the LNHA were kind of splitting it. She further stated when a candidate came in to apply for a position, the candidate would fill out their references, then at that point, either the LNHA or herself would call the references. She confirmed that should be done for all employees prior to being hired. The VPHR added that once the reference checks were done, Human Resources (HR) signed off on the bottom of the form that they had completed the reference check. The VPHR confirmed that if there was no signature at the bottom of the form, the reference check was not completed. She also stated that it was important that the reference checks were completed (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	because they needed to know who they were hiring to make sure there were no issues with them from previous employers, and know they were not putting the residents at risk. The VPHR stated that the LNHA was responsible for completing the background checks because they did not have an HR person. She added that background checks were completed after the reference checks were done, but before the candidate attended orientation. She further stated it was important to make sure that they were not putting the residents or the facility at risk. On 4/6/2026 at 2:55 PM, the surveyor conducted a follow-up interview with the LNHA who stated that he reviewed all the personnel files in question and cross referenced their hire dates with their start date and he confirmed that all the employees referenced above started working at the facility prior to the completion of a reference check and/or criminal background check.NJAC 8:39-4.1(a)5

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure the designated Infection Preventionist (IP) was dedicated solely to the infection prevention and control program (IPCP). This deficient practice was identified for one (1) of one (1) staff and was evidenced by the following:On 4/1/2026 at 10:46 AM, the surveyor interviewed the interim Director of Nursing (DON) who stated that she was hired at the facility as a part-time, 20 hours per week, Infection Preventionist (IP). However, since the former DON resigned she has been acting as both the full-time DON and part-time IP in the facility. The DON further explained that she was doing both the IP and DON positions with the help of the [NAME] President of Clinical Services (VPCS). On 4/2/2026 at 8:46 AM, the surveyor interviewed the interim DON/IP who stated that she had taken on the role as both the interim DON and part-time IP as of 2/11/26. She stated that she was originally hired for an IP position but the administration asked her to cover both positions until they had a permanent DON. The interim DON/IP stated that she had previously mainly worked as an IP in Pennsylvania. On 4/6/2026 at 11:53 AM, the surveyor interviewed the facility [NAME] President of Clinical Services (VPCS), Licensed Nursing Home Administrator (LNHA), DON, and Assistant Administrator in training who all confirmed that the IP assumed the role as the DON in addition to being the IP, as of 2/11/26, when the former DON resigned. NJAC 8:39-19.1(b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, it was determined that the facility failed to implement, revise and update care plans (CP) for 3 of 28 residents (Resident #7, #8, #17) reviewed. This deficient practice was evidenced by the following:1.) On 4/01/2026 at 1:01 PM, the surveyor interviewed Resident #17 who stated that he/she had wounds on the left foot and had a single lumen peripherally inserted central line (PICC) (a long, thin, flexible tube inserted into a peripheral vein (usually in the upper arm) and threaded into a large vein near the heart) in the left upper arm. The surveyor reviewed Resident #17's electronic medical record which revealed the following information: A review of the admission Record (admission summary) indicated that Resident #17 was admitted to the facility with diagnoses which included but was not limited to osteomyelitis (serious, often painful infection and inflammation of the bone caused by bacteria or fungi) and diabetes mellitus (DM). A review of the comprehensive Minimum Data Set (MDS), a assessment tool that facilitates a resident's care, dated 1/20/2026, reflected that the resident scored 12 out of 15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident was cognitively intact. The MDS also reflected that Resident #17 utilized a wheelchair, had open lesions on the foot and was on antibiotic therapy. A review of the Treatment Administration Record (TAR) revealed that there were no treatment orders or dressing change orders for the resident's left upper arm PICC line. The surveyor reviewed the resident's interdisciplinary care plan (ICP) which did not reflect documentation that the resident had a PICC line in the resident's left upper arm or interventions regarding the care of the resident's PICC line. A review of the TAR revealed that the resident had a treatment order dated 3/2/2026 to cleanse the right and left foot wounds with normal saline solution and apply Medi honey dressing external paste to be applied to the right and left foot non-pressure chronic ulcers and cover with a dry dressing and wrap with gauze daily. A review of the Wound Care Consult (WCC) dated 3/20/2026, indicated that the resident had wounds found on the left plantar foot and left mid plantar foot. The patient was also at risk of developing a pressure injury because of the following risk factors: diabetes and limited mobility. The following wounds were stable and required continued topical wound dressing therapy as noted above: left plantar foot and left mid plantar foot. Prognosis: the prognosis for this patient is good. Follow-up: follow up at an interval of one week. Goals: the overall goals for the wounds were wound stabilization and prevention of wound decline. Offloading: continue offloading: Turn per facility protocol. The surveyor reviewed the resident's Interdisciplinary Care Plan (ICP) which did not include any documentation that the resident had wounds on the left foot nor interventions for the care for the left foot wounds. On 4/01/2026 at 1:22 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who reviewed the physician's orders and confirmed that there were no orders to change the PICC line dressing, or (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change the cap on the PICC line or to monitor the site for infection, bleeding or dislodgement. The LPN then stated she would have to double check if there should be a PICC line dressing change order and stated that she was not sure. She confirmed that an ICP for both the PICC line and the left foot wounds were not developed and that there were no interventions implemented on the ICP for the care of the PICC line or the bilateral foot wounds. On 4/02/2026 at 8:53 AM, the surveyor interviewed the Director of Nursing (DON) who explained that PICC lines and wounds should be care planned with resident specific interventions so that the staff knew how to care for the resident. On 4/02/2026 at 10:30 AM, the surveyor interviewed a nurse who identified herself as the LPN night shift supervisor and confirmed that a care plan should have been developed for Resident #17's left foot wounds and PICC line. She also confirmed that the formulation of an ICP with resident specific interventions assisted the staff in caring for Resident #17 and provided information on the progression and healing of the wound. On 4/02/2026 at 1:49 PM, the surveyor interviewed the [NAME] President Clinical Services (VPCS) who confirmed that an ICP was not developed, and interventions were not implemented for Resident #17's PICC line and for the wounds located on the resident's feet. He stated that an ICP had since been developed after surveyor inquiry. 2.) On 3/30/2026 at 11:46 AM, during the initial tour of the facility, the surveyor observed Resident #7 lying in bed awake. The resident indicated that he/she received an anticoagulant via injection and had no complaints about bleeding or bruising. On 3/31/26 at 10:29 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #7. A review of the admission Record, (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; multiple fractures of the pelvis (the large bony structure near the base of the spine to which the legs are attached) with stable disruption of the pelvic ring, initial encounter for closed fracture, unspecified fracture of shaft of unspecified tibia (the larger of the two bones between the knee and the ankle), initial encounter for closed fracture, fracture of unspecified part of left clavicle (collar bone), subsequent encounter for fracture with delayed healing, difficulty in walking, and muscle weakness (generalized). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/08/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS indicated that the resident had no documented behaviors and was taking an anticoagulant. A review of the resident's Order Summary Report (OSR), dated as of 4/02/2026, included the following physician order (PO): A PO, dated 1/01/2026, for Lovenox Solution 30 mg (milligrams)/0.3 ml (milliters) (Enoxaparin Sodium) Inject 30 MG subcutaneously (just below the skin) every 12 hours for blood clotting prevention. Rotate site, may cause severe bleeding/bruising. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the resident's individual comprehensive care plan (ICCP) failed to indicate that the resident was prescribed an anticoagulant (Lovenox Sodium or Enoxaparin Sodium) with interventions to address the medications' potential side effects of severe bleeding and bruising. On 4/02/2026 at 9:23 AM, the surveyor interviewed the Registered Nurse (RN #2) who stated that when a resident was on Lovenox we anticipated that the resident was not walking and was not ambulatory. RN #2 stated that a care plan focus area for Lovenox should have been implemented by nursing upon admission to the facility in the base line care plan within the first 48 hours of admission for proper technique of administration which included rotation of the injection site for absorption and comfort, and to address the potential side effects of the medication which included a risk for bleeding and pain at the injection site. RN #2 stated that the care plan then should have been updated within four to six weeks after the resident progressed with physical therapy and rehabilitation to determine if we could have stopped the Lovenox. RN #2 stated that the MDS Coordinator was also responsible for care plan development, as the care plans were discussed as a team at morning meeting. RN #2 further stated that the [NAME] President Clinical Services (VPCS) and the Licensed Nursing Home Administrator (LNHA) were responsible for care plan meetings which included both long-term care and subacute rehabilitation resident care plans. On 4/02/2026 at 10:15 AM, the surveyor interviewed the MDS Coordinator who stated that if the care plan intervention included medications then nursing was responsible for care plan development. The MDS further stated that the Director of Nursing (DON) was responsible for reviewing the care plans for accuracy. On 4/02/2026 at 10:33 AM, the surveyor interviewed the DON who stated that if a resident were on Lovenox it should definitely have been on the resident's care plan so that nursing could look for both bruising and bleeding. The DON stated that she reviewed the care plans when it was brought to her attention, when the resident went out to the hospital and upon return, and with new orders. The DON stated that nursing held care plan meetings as needed. On 4/02/2026 at 10:44 AM, the surveyor interviewed the [NAME] President Clinical Services (VPCS) who stated that the resident should have had a care plan in place to address the resident's risk for bruising and bleeding on the base line care plan. When the surveyor reviewed the base line care plan with the VPCS, the base line care plan failed to address the resident's risk for bruising and bleeding and only included to check labs. The VPCS then confirmed that Lovenox (enoxaparin) was not documented on the resident's comprehensive care plan, and he stated that it absolutely should have been. The VPCS further stated that the facility liked the MDS Coordinator to review the care plan and notify clinical leadership of which care plans were to be reviewed prior to comprehensive care plan development. On 4/02/2026 at 1:25 PM, the surveyor informed the Licensed Nursing Home administrator (LNHA) of the concerns related to the facility's failure to develop and implement a comprehensive care plan for a resident who was prescribed Lovenox (enoxaparin). 3. On 3/30/2026 at 11:26 AM, the surveyor observed Resident #8 in the dining room seated in a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair at a table with two other residents and was participating in an activity. The surveyor reviewed the medical record for Resident #8. A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; unspecified dementia, with mood disturbance, paroxysmal atrial fibrillation (an irregular, rapid heart rhythm that starts suddenly and stops on its own within seven days), and hypertensive heart disease without heart failure (heart complications caused by long-term high blood pressure). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 2/03/26, section C for cognitive patterns revealed the resident had a Brief Interview of Mental Status of 3 out of 15, meaning the resident was severely cognitively impaired. Section I of the MDS, active diagnoses indicated the resident had been diagnosed with Atrial Fibrillation. A further review of section N- Medications revealed the resident was prescribed and was taking an anticoagulant (medication used to prevent or reduce blood clots). A review of the Order Summary Report (OSR) for active orders dated as of 4/02/26, revealed an active order dated 2/03/26, for an anticoagulant; Apixaban oral tablet 2.5 mg (milligram) (apixaban); give one tablet by mouth two times a day related to paroxysmal Atrial Fibrillation. May increase risk for bleeding. Please observe for any bruising. Please observe for any bruising, dark urine and black tarry stool. A review of the resident's individualized comprehensive care plan (ICCP) did not include a focus area or interventions to address Resident #8's diagnosis of Atrial Fibrillation or the use of an anticoagulant medication. On 4/02/2026 at 11:45 AM the surveyor interviewed the resident's Licensed Practical Nurse #3 (LPN #3) who confirmed Resident #8 was prescribed Apixaban, an anticoagulant. LPN #3 further confirmed Resident #8 should have a care plan to address the use of an anticoagulant. On 4/02/2026 at 11:51 AM, the surveyor interviewed the Registered Nurse #2 (RN #2) who stated she was responsible for creating resident care plans and that accurate care plans were needed to best take care of the residents. RN #2 confirmed Resident #8 should have a care plan with a focus for the use of an anticoagulant and what side effects to look for as well as precautions to take. On 4/02/2026 at 1:29 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed nursing was responsible for initiating care plans, and that Resident #8 should have a care plan for use of an anticoagulant that included monitoring for bleeding or bruising. On 4/02/2026 at 1:30 PM, the surveyor interviewed the Regional [NAME] President of Clinical Services (VPCS) who confirmed a resident who was prescribed an anticoagulant should have a care plan for its use which addresses monitoring for potential side effects. A review of the Comprehensive Resident Centered Care Plans" policy, dated 5/01/25, included: It is the policy of the facility to promote seamless interdisciplinary care for the residents by utilizing interdisciplinary plan of care based on assessment, planning, treatment, service and intervention. It is utilized to plan for and manage resident care as evidenced by documentation for admission through (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discharge for each resident. The policy specified that services provided or arranged by the facility, as outlined by the comprehensive care plan, would meet professional standards of quality. The care plan will identify priority problems and needs to be addressed by the interdisciplinary team, and will reflect the resident's strengths, limitations and goals.The care plan will contain information about the physical, emotional/psychological, psychosocial, spiritual, educational and environmental needs as appropriate.The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights.and include measurable objectives and time frames to meet a resident's needs that were identified in comprehensive assessment. The resident will have the right to participate in the development and implementation of his or her person-centered plan of care. .The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set fort 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 comprehensive assessment. NJAC 8:39-11.2 (d), 27.1(a)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a resident's refusal of an anticoagulant (a medication that reduces the risk of blood clot formation) was promptly communicated to the resident's physician and documented within the progress notes of the resident's electronic medical record (EMR) in accordance with professional standards of nursing practice.This deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for the use of an anticoagulant and was evidenced by the following:Refer to F656 and F756Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 3/30/2026 at 11:46 AM, during the initial tour of the facility, the surveyor observed Resident #7 lying in bed awake. The resident indicated that he/she received an anticoagulant via injection and had no complaints about bleeding or bruising.On 3/31/2026 at 10:29 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #7. A review of the admission Record, (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; multiple fractures of pelvis (the large bony structure near the base of the spine to which the legs are attached) with stable disruption of the pelvic ring, initial encounter for closed fracture, unspecified fracture of shaft of unspecified tibia (the larger of the two bones between the knee and the ankle), initial encounter for closed fracture, fracture of unspecified part of left clavicle (collar bone), subsequent encounter for fracture with delayed healing, difficulty in walking, and muscle weakness (generalized). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/8/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS indicated that the resident had no documented behaviors and was taking an anticoagulant.A review of the resident's individual comprehensive care plan (ICCP) failed to indicate that the resident was prescribed an anticoagulant.A review of the resident's Order Summary Report (OSR), dated as of 4/2/2026, included the following physician order (PO):A PO, dated 1/1/2026, for Lovenox Solution 30 MG (milligrams)/0.3 ML (milliliters) (enoxaparin sodium) Inject 30 MG subcutaneously (just below the skin) every 12 hours for blood clotting prevention. Rotate site, may cause severe bleeding/bruising.On 3/31/2026 at 12:17 PM, the surveyor observed the resident lying in bed. When interviewed, the resident stated that he/she asked the doctor if they really needed to stay on Lovenox because they were now able to walk around a lot. The resident further stated that he/she did not like to receive the injection in their abdomen and sometimes refused the medication. The resident stated that the medication was originally prescribed due to immobility, but now he/she could move around, and they questioned the continued need for the medication. A review of Resident #7's January 2026 Medication Administration Record (MAR) revealed a legend with Chart Codes/Follow Up Codes which indicated a code of 2=Drug Refused. The surveyor observed that a 2=Drug Refused value was documented for Resident #7's refusal of the PO for Lovenox Solution 30 MG/0.3 ML (Enoxaparin Sodium) Inject 30 MG subcutaneously every 12 hours for blood clotting prevention Rotate Site, May cause severe (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bleeding/bruising that was ordered at 10:00 AM (1000) and 10:00 PM (2200). Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 1/13/26, 1/18/26, 1/19/26, 1/28/26, and 1/30/26. Further review of the MAR revealed that Lovenox (Enoxaparin Sodium) was also documented as refused by the resident at 10:00 PM on the following dates: 1/16/26, 1/17/26, 1/18/26, 1/19/26, 1/28/26, 1/30/26, and 1/31/26.A review of Resident #7's February 2026 MAR revealed that Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 2/16/26, 2/17/26, 2/19/26, 2/20/26, 2/23/26, 2/24/26, 2/25/26, and 2/26/26. Further review of the MAR revealed that Lovenox (Enoxaparin Sodium) was also documented as refused by the resident at 10:00 PM on the following dates: 2/01/26, 2/02/26, 2/03/26, 2/04/26, 2/09/26, 2/10/26, 2/11/26, 2/13/26, 2/14/26, and 2/17/26.A review of Resident #7's March 2026 MAR revealed that Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 3/02/26, 3/03/26, 3/05/26, 3/06/26, 3/07/26, 3/10/26, 3/11/26, 3/16/26, 3/19/26, 3/20/26, 3/23/26, 3/24/26, 3/25/26, 3/26/26, 3/28/26, 3/29/26, 3/30/26, and 3/31/26. Further review of the MAR revealed that Lovenox (Enoxaparin Sodium) was also documented as refused by the resident at 10:00 PM on the following dates: 3/6/26, 3/9/26, 3/23/26, 3/25/26, 3/28/26, 3/29/26, and 3/30/26. A review of Resident #7's April 2026 MAR revealed that Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 4/01/26, and 4/02/26. There was no documented incident of resident refusal on 4/01/26 at 10:00 PM. On 4/01/2026 at 10:20 AM, the surveyor interviewed Registered Nurse (RN #1) who stated that she had no knowledge that Resident #7 had refused their Lovenox (enoxaparin sodium). RN #1 stated that if a medication were refused, she would educate the resident and notify the doctor or the resident's Power of Attorney (POA, responsible party) and document the education and the notification in the progress notes (PN).On 4/02/2026 at 9:07 AM, the surveyor phoned the facility Medical Director (MD) who was the resident's assigned physician. The MD stated that the resident was ordered Lovenox for a fractured acetabulum (the socket of the hip bone, into which the head of the femur (the longest bone in the leg) fits and pelvic fracture and the risk for deep vein thrombosis (DVT, blood clot) was pretty high. The MD stated that it was recommended by the head of clinical research that the resident be on Lovenox for eight weeks. The MD stated that if a resident told him that they were not taking the medication, it was reasonable to stop the medication, and it was also reasonable to continue the medication. The MD further stated that he had personally discussed it with the resident and told the resident that he/she needed to take it. When the surveyor asked the MD if he documented the resident education in the resident's Progress Notes (PN) the MD stated documentation can go by the wayside in a burdened health care environment. On 4/02/26 at 12:49 PM, the surveyor phoned the CP who stated that she was not the primary CP for the facility and needed to review the resident's documentation. The CP stated that if we see a code of 2 for refusals that was something that we should have picked up as an irregularity. The CP stated that she did not note that the nurse's had documented refusal of Lovenox in the PN and notified the physician about it. The CP stated that it was something that the CP should have picked up both in February and March due to the number of doses refused. The CP stated that a recommendation should have been made to notify the physician of resident refusals and document it so that the physician was aware. The CP stated that we could have also discussed the refusal, lack of documentation and consideration of an oral anticoagulant to help the resident with compliance.On 4/02/2026 at 1:25 PM, the surveyor informed the Licensed Nursing Home administrator (LNHA) of the concerns related to the facility's failure to document physician notification, and resident education of multiple instances of the resident's refusal of Lovenox (enoxaparin) in accordance with professional standards of nursing practice.A review of the facility's Medication Administration policy, dated 5/1/2025, included .If a dose of regularly scheduled medication is withheld, refused, or given at other than the schedule time.,the administering person will document it in the EMR. If (two consecutive doses) of a vital medication are withheld or refused, the physician is notified. NJAC 27.1(a)

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	315317	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at the Pines	29 North Vermont Ave Atlantic City, NJ 08401

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to ensure that a resident received care and services for the provision of dressing changes to a peripherally inserted central catheter (PICC-is a long, thin, flexible tube inserted into a peripheral vein (usually in the upper arm) and threaded to a large vein near the heart) site consistent with professional standards of practice. This deficient practice was identified for 1 of 1 resident (Resident #17) reviewed for parenteral medication administration and was evidenced by the following:A review of the admission Record (admission summary) indicated that Resident #17 was admitted to the facility with the diagnoses which included but was not limited to osteomyelitis (serious, often painful infection and inflammation of the bone caused by bacteria or fungi) and diabetes mellitus (DM). A review of the comprehensive Minimum Data Set (MDS), a assessment tool that facilitates a resident's care, dated 1/20/2026, indicated that the resident scored 12 out of 15 on the Basic Interview for Mental Status (BIMS) which indicated that the resident was cognitively intact. The MDS also reflected that Resident #17 utilized a wheelchair, had open lesions on the foot and was on antibiotic therapy. The surveyor reviewed Resident #17's electronic medical record (EMR) which revealed the following information: A review of a physician's order (PO), dated 2/27/2026, indicated that Invanz (antibiotic) 1 gram was to be given intravenously one time a day for 14 days and discontinued on 3/14/2026. A review of a PO, dated 3/16/2026, indicated that Ertapenem Sodium Solution (antibiotic) Reconstituted 1 GM Use 1 gram was to be given intravenously every 24 hours for osteomyelitis (OM) for 10 Days and discontinued 3/24/2026. A review of a PO, dated 3/27/2026, indicated that Ertapenem Sodium Solution Reconstituted 1 GM Use 1 gram was to be administered intravenously every 24 hours for osteomyelitis (OM) for 10 Days and to be discontinued on 4/6/2026. On 4/1/2026 at 1:01 PM, the surveyor interviewed Resident #17 who stated that he had wounds on the left foot and had a single lumen peripherally inserted central line (PICC) in the left upper arm. The surveyor observed that the dressing to the PICC line access site was intact and undated. The dressing tape was peeling on the sides. Resident #17 stated that they were not sure when the dressing to the PICC line access site was changed.A review of Resident #17's Medication Administration Record (MAR) and the Treatment Administration Record (TAR) revealed that the resident did not have a physician's order to change the caps on the PICC line or dressing changes for the access site the entire month of March 2026. There were also no orders to monitor the PICC line site for signs and symptoms of infection, bleeding or dislodgement. A review of the February 2026 TAR revealed that the last time the resident had a PICC line dressing change was on February 11th 2026. On 4/1/2026 at 1:22 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who reviewed the physician's orders and confirmed that there was not an order to change the PICC line dressing, change the cap on the PICC line or to monitor the site for infection, bleeding or dislodgement. The LPN then stated she would have to double check if there should be a PICC line dressing change order and stated she was not sure. On 4/2/2026 at 8:53 AM, the surveyor interviewed the Director of Nursing (DON) who stated that when a resident had a PICC line, the physician orders included the size of the catheter, the date it was inserted, type of IV medication to be infused, what infection the resident was being treated for, flushes to keep the PICC patent and dressing changes to the access site to include cap changes. She also added that the access site needed to be monitored for signs and symptoms of infection and patency. The DON explained that PICC line cap and dressing changes were to be completed weekly to keep the area free of infection. She stated that the staff should be inspecting the access site weekly to ensure there were no signs and symptoms of infection. On 4/2/2026 at 9:09 AM, the surveyor interviewed the Medical Director (MD) who stated orders for PICC maintenance should include dressing changes and PICC line monitoring. He stated that it was a standard of care and should include orders regarding the date the PICC line was inserted, line size, dressing changes and monitoring of the PICC line access site for (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection, bleeding or dislodgement. He further stated that orders should also include what type of infection the antibiotics were treating. The MD confirmed that in the absence of dressing change orders, the resident could be at risk for infection at the PICC line site.On 4/2/2026 at 1:49 PM, the surveyor interviewed the [NAME] President Clinical Services (VPCS) who confirmed that there were no dressing change orders for Resident #17's PICC line access site since 2/11/26. He stated that this was the last documented date that the PICC line access site dressing was changed. The VPCS further stated that since surveyor inquiry, the facility obtained PICC line dressing change orders and changed the residents PICC line dressing. The VPCS also confirmed that the resident's PICC line access site was free from infection and that no harm came to Resident #17.A review of the facility policy dated 5/1/25 and titled, Peripheral and Midline IV Dressings indicated that the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened, soiled catheter-site dressings. The policy indicated that site care and dressing change were to be performed at established intervals or immediately if the integrity of the dressing was compromised (damp, loosened and visibly soiled). Dressing changes were to be done at least every seven days, and the access site was to be assessed every shift for dislodgement, redness, tenderness, swelling, infiltration, induration, elevated body temperature and drainage. NJAC 8:39-25.2 (c)5

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review, and review of pertinent facility documents, it was determined that the Consultant Pharmacist (CP) failed to report irregularities found in the medical record to the facility. This deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for anticoagulant (a medication that reduces the risk of blood clot formation) usage and was evidenced by the following:On 3/30/2026 at 11:46 AM, during the initial tour of the facility, the surveyor observed Resident #7 lying in bed awake. The resident indicated that he/she received an anticoagulant via injection and had no complaints about bleeding or bruising.On 3/31/26 at 10:29 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #7. A review of the admission Record, (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; multiple fractures of pelvis (the large bony structure near the base of the spine to which the legs are attached) with stable disruption of the pelvic ring, initial encounter for closed fracture, unspecified fracture of shaft of unspecified tibia (the larger of the two bones between the knee and the ankle), initial encounter for closed fracture, fracture of unspecified part of left clavicle (collar bone), subsequent encounter for fracture with delayed healing, difficulty in walking, and muscle weakness (generalized). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/8/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS indicated that the resident had no documented behaviors and was taking an anticoagulant. A review of the resident's individual comprehensive care plan (ICCP) failed to indicate that the resident was prescribed an anticoagulant. A review of the resident's Order Summary Report (OSR), dated as of 4/2/2026, included the following physician order (PO):A PO, dated 1/1/2026, for Lovenox Solution 30 MG (milligrams)/0.3 ML (milliters) (Enoxaparin Sodium) Inject 30 MG subcutaneously (just below the skin) every 12 hours for blood clotting prevention. Rotate site, may cause severe bleeding/bruising. On 3/31/2026 at 12:17 PM, the surveyor observed the resident lying in bed. When interviewed, the resident stated that he/she asked the doctor if they really needed to stay on Lovenox because they were now able to walk around a lot. The resident further stated that he/she did not like to receive the injection in their abdomen and sometimes refused the medication. The resident stated that the medication was originally prescribed due to immobility, but now he/she could move around and they questioned the continued need for the medication. On 3/31/2026 at 12:58 PM, the surveyor requested to view the Consultant Pharmacist recommendations for the past six months and was presented with a Consultant Pharmacist's Monthly Report dated 1/15/2026, which failed to indicate that the CP indicated an irregularity with Lovenox (Enoxaparin Sodium). The CP's responsibility was to review all resident's medications monthly for discrepancies, continued monitoring, and correct dosing of medications. A review of Resident #7's January 2026 Medication Administration Record (MAR) revealed a legend with Chart Codes/Follow Up Codes which indicated a code of 2=Drug Refused. The surveyor observed that a 2=Drug Refused value was documented for Resident #7's refusal of the PO for Lovenox Solution 30 MG/0.3 ML (Enoxaparin Sodium) Inject 30 MG subcutaneously every 12 hours for blood clotting prevention Rotate Site, May cause severe bleeding/bruising that was ordered at 10:00 AM (1000) and 10:00 PM (2200). Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 1/13/26, 1/18/26, 1/19/26, 1/28/26, and 1/30/26. Further review of the MAR revealed that Lovenox (Enoxaparin Sodium) was also documented as refused by the resident at 10:00 PM on the following dates: 1/16/26, 1/17/26, 1/18/26, 1/19/26, 1/28/26, 1/30/26, and 1/31/26. A review of Resident #7's February 2026 MAR revealed that Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 2/16/26, 2/17/26, 2/19/26, 2/20/26, 2/23/26, 2/24/26, 2/25/26, and 2/26/26. Further review of the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MAR revealed that Lovenox (Enoxaparin Sodium) was also documented as refused by the resident at 10:00 PM on the following dates: 2/1/26, 2/2/26, 2/3/26, 2/4/26, 2/9/26, 2/10/26, 2/11/26, 2/13/26, 2/14/26, and 2/17/26.A review of Resident #7's March 2026 MAR revealed that Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 3/2/26, 3/3/26, 3/5/26, 3/6/26, 3/7/26, 3/10/26, 3/11/26, 3/16/26, 3/19/26, 3/20/26, 3/23/26, 3/24/26, 3/25/26, 3/26/26, 3/28/26, 3/29/26, 3/30/26, and 3/31/26. Further review of the MAR revealed that Lovenox (Enoxaparin Sodium) was also documented as refused by the resident at 10:00 PM on the following dates: 3/6/26, 3/9/26, 3/23/26, 3/25/26, 3/28/26, 3/29/26, and 3/30/26. A review of Resident #7's April 2026 MAR revealed that Lovenox (Enoxaparin Sodium) was documented as refused by the resident at 10:00 AM on the following dates: 4/1/26, and 4/2/26. There was no documented incidence of resident refusal on 4/1/26 at 10:00 PM. On 4/1/2026 at 10:20 AM, the surveyor interviewed Registered Nurse (RN #1) who stated that she had no knowledge that Resident #7 had refused their Lovenox (Enoxaparin Sodium). RN #1 stated that if a medication were refused, she would educate the resident and notify the doctor or the resident's Power of Attorney (POA, responsible party) and document the education and the notification in the progress notes (PN). On 4/2/2026 at 9:07 AM, the surveyor phoned the facility Medical Director (MD) who was the resident's assigned physician. The MD stated that the resident was ordered Lovenox for a fractured acetabulum (the socket of the hip bone, into which the head of the femur (the longest bone in the leg) fits and pelvic fracture and the risk for deep vein thrombosis (DVT, blood clot) was pretty high. The MD stated that it was recommended by the head of clinical research that the resident be on Lovenox for eight weeks. The MD stated that if a resident told him that they were not taking the medication, it was reasonable to stop the medication, and it was also reasonable to continue the medication. The MD further stated that he had personally discussed it with the resident and told the resident that he/she needed to take it. When the surveyor asked the MD if he documented the resident education in the resident's Progress Notes (PN) the MD stated documentation can go by the wayside in a burdened health care environment. On 4/2/26 at 12:49 PM, the surveyor phoned the CP who stated that she was not the primary CP for the facility and needed to review the resident's documentation. The CP stated that if we see a code of 2 for refusals that was something that we should have picked up as an irregularity. The CP stated that she did not note that the nurse's had documented refusal of Lovenox in the PN and notified the physician about it. The CP stated that was something that the CP should have picked up both in February and March due to the number of doses refused. The CP stated that a recommendation should have been made to notify the physician of resident refusals and document it so that the physician was aware. The CP stated that we could have also discussed the refusal, lack of documentation and consideration of an oral anticoagulant to help the resident with compliance. The CP further stated that we should have noted it in February and brought it to the facility's attention in March. On 4/6/2026 at 8:47 AM, the surveyor reviewed the resident's PN and noted that the CP performed a Medicine Regimen Review (MRR) on 2/13/26. On 4/6/2026 at 11:53 AM, the [NAME] President Clinical Services (VPCS) provided the surveyor with the Consultant Pharmacist's Monthly Report dated 2/13/2026, which failed to indicate that the CP notified the facility of the resident's refusal of Lovenox (Enoxaparin Sodium) for both January and February 2026. On 4/6/2026 at 12:01 PM, the surveyor shared their concerns with the Consultant Pharmacist's failure to identify the resident's refusal of Lovenox (Enoxaparin Sodium), and the lack of both physician and nursing documentation related to the refusals in both the January and February 2026 in the Consultant Pharmacist's Monthly Reports. The Licensed Nursing Home Administrator (LNHA) stated that the CP should have picked up on the resident's Lovenox refusal, and alerted the facility, as that was what he was hired for. On 4/07/2026 at 10:34 AM, In a post-survey follow-up phone call from the CP, she stated that she verified that the assigned CP was at the facility on 3/12/26, and should have not missed the refused dosages of Lovenox, but we did. The CP acknowledged that the CP should have noted the resident refusals and notified the facility.A review of the facility Pharmacy Services-Drug (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regimen Review policy, dated 5/1/2025, included: .The drug regimen of reach resident will be reviewed at least monthly by a licensed pharmacist, and the pharmacist will report any irregularities to the attending physician, the facility's medical director and the director of nursing and these reports will be acted upon. Irregularities include, but are not limited to, any drug that meets the following criteria: .Excessive duration; orWithout adequate monitoring;.NJAC 8:39 29.3(a)5

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, record review and review of pertinent facility documents, it was determined that the facility failed to ensure that the required members were present during the quarterly Quality Assurance and Performance Improvement (QAPI) Committee Meetings. This deficient practice occurred during 4 of 4 meetings reviewed and was evidenced by the following:On 4/6/2026 at 9:57 AM, the surveyor was provided with the last four quarters of the QAPI meeting sign-in sheets for review that were dated July 31, 2025, April 2025 (date not specified), October 2025 (date not specified), and 1/29/2026 and reviewed them with the Licensed Nursing Home Administrator. The LNHA stated that it was mandatory for the Medical Director (MD), LNHA, Director of Nursing (DON), and the Infection Preventionist (IP) to attend the QAPI meetings because they were core in-house staff and their signature on the sign-in sheet was essential to validate that they were in attendance at the quarterly meetings. The LNHA reviewed the QAPI Meeting Sign-In Sheet dated April 2025 and confirmed that the DON had not signed the sign-in sheet to demonstrate that she was in attendance and that there was no documented evidence that a designee was present on her behalf. The LNHA reviewed QAPI Meeting Sign-In Sheet dated July 31, 2025, and confirmed that the DON had not signed the sign-in sheet to demonstrate that she was in attendance and that there was no documented evidence that a designee was present on her behalf. The LNHA reviewed the QAPI Meeting Sign-In Sheet dated October 2025 and stated that he had not signed the sign-in sheet to indicate that he was in attendance. The LNHA reviewed the QAPI Meeting Sign-In Sheet dated 1/29/2026 and confirmed that the former DON was still working at the facility at that time, but had not signed to indicate that she was in attendance. The LNHA stated that if the required staff members had not signed the QAPI Sign-In Sheets there was no way to validate that they had been in attendance at the meetings as required. The LNHA further stated that it was important for the core staff to be in attendance at the QAPI meetings because their input and expertise was required for the topics of discussion. A review of the facility's Quality Assurance Performance Improvement Policy dated 4/28/2025, included:It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of outcomes of care and quality of life and addresses all the care and unique services the facility provides.the QAA Committee shall be interdisciplinary and shall:Consist at a minimum of:The Director of Nursing Services; The Medical Director or his/her designee; At least three other members of the facility's staff, at least one of which must be the Administrator, owner, board member or other individual in a leadership role; and the Infection Preventionist.The QAA committee must sign to verify their approval of all plans of correction written .NJAC 8:39-33.1(b)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of facility documents, it was determined that the facility failed to maintain a clean, safe, and home like environment for one resident room (room [ROOM NUMBER]) on 1 of 4 nursing units (Veteran's Unit). This deficient practice was evidenced by the following:On 3/31/2026 at 12:39 PM, the surveyor entered room [ROOM NUMBER] with an unsampled resident's permission and noted that one of the square shaped ceramic tile flooring pieces had been removed from the subflooring and was placed over the top of the opening from which it was previously adhered to, and the surveyor noted a shallow opening in the flooring at the foot of bed C which was not occupied at that time. When interviewed the unsampled resident stated that one of the other two residents who also resided in the room had previously reported the broken floor tile to a staff member, but he/she did not know which staff member that they reported it to. The surveyor also noted that the flooring around the perimeter of the room had a thick build-up of dirt in the corresponding flooring and wall junctures.On 4/1/2026 at 10:48 AM, the surveyor interviewed Certified Nursing Assistant (CNA #2) who accompanied the surveyor into room [ROOM NUMBER] and she stated that she had not noticed the chipped, loose floor tile. At that time, the surveyor noted that the floor tile had been set back into place, and the corner of the tile was chipped and left a small, opened area in the corner of the tile. When the surveyor stepped on the tile, the tile moved loosely from side to side and was not secured to the subflooring. CNA #2 stated that she would alert maintenance via the electronic reporting system [software name redacted] because the tile needed to be glued down or replaced to avoid someone slipping. The surveyor then showed CNA #2 the soiled perimeter of the flooring and asked how frequently the facility carbolized (deep cleaned) the room and she stated that she was unsure and did not know the housekeeping schedule.On 4/1/2026 at 10:48 AM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who accompanied the surveyor into room [ROOM NUMBER] and she stated that she had not noticed the chipped, loose floor tile which she stated occurred from wear and tear. LPN #1 stated that if the floor tile was not repaired then a resident could trip and get hurt. LPN #1 further stated that the repair should be called into the maintenance department as soon as possible.On 4/1/2026 at 10:55 AM, the surveyor attempted to interview the Housekeeper (HK #1) who stated that she mopped the resident's flooring daily. HK #1 was then unable to answer any additional surveyor questions due to a language barrier.On 4/1/2026 at 1:46 PM, the surveyor interviewed Maintenance who stated that nobody from the nursing department used the electronic reporting system [software name redacted] to communicate with the maintenance department and he was unable to provide the surveyor with documented evidence of any notifications from staff with requests to repair the broken floor tile. He further stated that someone was supposed to glue the tile down.On 4/1/2026 at 2:00 PM, in a later interview with Maintenance he confirmed that the maintenance department had received a telephone call today after surveyor inquiry to report the chipped and loose floor tile. He stated that the floor tile would be repaired and taped down today.On 4/2/2026 at 1:25 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team who stated that a loose floor tile posed a safety issue if the resident slipped and fell. The Director of Nursing (DON), who was present stated that if maintenance were to tape the floor tile down then both bacteria and germs could stick to the tape and posed an infection control issue. The LNHA further stated that the Maintenance solution of taping the tile down was not a viable solution. The surveyor asked how frequently resident rooms were carbolized and the [NAME] President of Clinical Services (VPCS) who was present at that time, stated that there was a schedule of rooms that were to be carbolized and he agreed to provide the surveyor with documented evidence of when room [ROOM NUMBER] was last carbolized. The facility failed to provide the surveyor with documented evidence that the room had been carbolized prior to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at the Pines	29 North Vermont Ave Atlantic City, NJ 08401

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor inquiry.A review of the facility's Safe Environment policy, dated 5/1/2025, included: It is the policy of the facility to provide a safe and clean environment in accordance to [sic] State and Federal regulations.The facility will be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public.The facility will provide: .housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.NJAC 8:39-31.4(a)(b)(f)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Complaint #2632496 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide incontinence care to residents who were unable to carry out activities of daily living (ADLs) for 2 out of 8 residents (Resident #1 and #36) observed during an incontinence tour.This deficient practice was evidenced by the following:On 4/2/2026 at 9:15 AM, the surveyor conducted an incontinence tour with Licensed Practical Nurse/Nursing Supervisor (LPN/NS) #1 on the third floor. Resident #36 was observed lying in bed. When Resident #36 was asked if their incontinence brief was clean and dry, they stated that it was wet and they needed to be changed. They added that they had been wet since 5 AM. They further stated that at 5 AM that morning, they asked their assigned Certified Nursing Assistant (CNA) to change them, but the CNA left the room and never returned to change them.At that time, with the resident's permission, LPN/NS #1 checked the resident's brief. The outer layer was noted with a blue line, which indicated that the resident's brief was wet. LPN/NS #1 opened the resident's brief and confirmed that it was soiled with urine. She then stated that she was going to inform the resident's CNA to change them. Resident #36 further stated that they used to get changed at 5 AM in the morning, but for the past week, they have not been changing them at that time. When asked what happens when they need to be changed between breakfast and lunch, they stated, Nothing happens.At that time, the LPN/NS #1 went to get a CNA to change Resident #36.On 4/2/2026 at 9:30 AM, the surveyor, accompanied by LPN/NS #1, conducted another incontinence tour on the 1st floor Ventilation Unit. Resident #1 was observed resting in bed. When LPN/NS #1 removed the resident's sheet, a large amount of dark brown loose feces was observed protruding out of the resident's brief and onto both legs. The feces were noted to be dried around the perimeter.At 9:32 AM, immediately following the observation, the surveyor interviewed Certified Nursing Assistant (CNA) #1, who stated that she was about to give an unsampled resident a bath, but before she could bathe them, she had to get Resident #48 off the commode first. When asked about the last time Resident #1's brief was changed, she stated that the night person last changed Resident #1, and she had not changed the resident during her shift. She added that she would usually check all the residents between 9:00 AM to 9:30 AM to see if they were soiled. CNA #1 was informed that Resident #1 was soiled with feces. She stated that she was unable to change them right away because she was waiting for Resident #48 to finish on the commode, and she also had a resident waiting to be showered. She added that she was the only CNA assigned to that unit on that shift for that day. She also stated that if she went in to change Resident #1, she would have to leave the door closed and she would not be able to hear the call bell for Resident #48, who was on the commode. She added that Resident #1 was a heavy wetter and they needed to be checked more frequently. She also stated that she had planned to check Resident #1 before she started the unsampled resident's bath, because she knew that it would take her a long time to give them a bath.At that time, LPN/NS #1 stated that she would ask a nurse for assistance with Resident #1 and ensure that they were changed.On 4/2/2026 at 9:46 AM, the surveyor further interviewed LPN/NS #1, who stated that the CNAs were responsible for doing their rounds at the beginning of each shift to make sure all the residents were clean and dry. She added that, if the resident was wet or soiled, her expectation was that the resident would get immediate attention, especially with the population of residents. LPN/NS #1 further stated that the residents on the ventilation unit required more frequent checks at a minimum of every hour because they could not use the call bell.On 4/2/2026 at 1:52 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #36.A review of the admission Record (an admission summary) revealed that the resident had diagnoses which included: paralytic gait (an abnormal walking pattern caused by muscle weakness or paralysis, typically resulting from neurological conditions like strokes, spinal cord injuries, or nerve damage), communication deficit, and cardiac arrhythmias.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/28/2025, indicated that the resident had a (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Brief Interview for Mental Status score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that the resident required assistance with toileting and was frequently incontinent of bladder and bowel.A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area dated 7/2/2024, which included that the resident had bladder incontinence related to the disease process. Interventions included: assisting with toileting as needed and establishing voiding patterns.On 4/2/2026 at 2:30 PM, the surveyor reviewed the EMR for Resident #1.A review of the admission Record (an admission summary) revealed that the resident had diagnoses which included: dependence on a ventilator, pressure ulcer of the sacral region, and anxiety.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 3/12/2026, revealed that Resident #1 was absent of spoken words, and their hearing and vision were highly impaired. The MDS further revealed that the resident was always incontinent of bowel and frequently incontinent of urine and was dependent on staff for all ADLs.A review of the Individualized Comprehensive Care Plan (ICCP) did not include activities of daily living (ADLs).On 4/6/2026 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the CNAs should be on top of their residents and need to check the residents every couple of hours to ensure that they were clean and dry, especially the heavy wetters. She added that as soon as CNAs started their shift and before they leave, they must make sure that everyone was fresh for the next shift.A review of the facility's Activities of Daily Living (ADLs)/Maintain Abilities policy, dated 5/1/2025, included, .The facility will provide care and services for the following activities of daily living: A. Hygiene -bathing, dressing, grooming, and oral care.A review of the facility's Incontinence policy dated 5/1/2025 included, It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter unless clinically necessary and promotes urinary continence of its residents in accordance with State and Federal Regulations.2. For the resident with urinary incontinence, based on the resident's comprehensive assessment, the facility will ensure that: .c. 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. 3. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility will ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much bowel function as possible.NJAC 8:39-27.2 (h)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that an air mattress was accurately set according to the resident's weight. This deficient practice was identified for 1 of 2 residents (Residents #1) reviewed for pressure ulcers and was evidenced by the following: On 3/31/2026 at 12:36 PM, the surveyor observed Resident #1 in bed on an air mattress set at 200 pounds.The surveyor reviewed the medical record for Resident #1.A review of the admission Record (an admission summary), revealed the resident had diagnoses which included: Dependence on ventilator, pressure ulcer of sacral region, and anxiety.A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 3/12/2026, revealed that Resident #1 was absent of spoken words, and their hearing and vision was highly impaired The MDS further revealed that the resident was at risk for pressure ulcers and required a pressure reducing device for their bed and the resident was totally dependent on staff.A review of the individual comprehensive care plan (ICCP) included a focus area, dated 9/8/2025, for a potential for impaired skin integrity. Interventions included: educate resident/representative about the proper usage of pressure reducing devices.A review of the Weights Summary revealed that Resident #1's weighed 114.6 lbs. (pounds) ton 3/5/2026.A review of the physician's orders (PO) included a PO to cleanse left buttock with saline, pat dry, and apply zinc, one time a day for wound care.Further review of the PO revealed that there was no physician's order for an air mattress.On 4/2/2026 at 9:30 AM, the surveyor, accompanied by the Licensed Practical Nurse/Nurse Supervisor (LPN/NS) #1 conducted a follow-up visit to the resident's room. Resident #1was observed in bed on the air mattress which was set at 300 lbs.At that time, LPN/NS #1 confirmed that the air mattress was set on 300.On 4/2/2026 at 9:49 AM, the surveyor interviewed LPN #1 who stated that the nurses make sure the air mattresses were plugged in, inflated, and functioning properly. She added that the settings were checked every time they moved the resident. She further stated that she pressed on the mattress to make sure that it was still inflated and that was how she knew that it was on the right setting. She also added that she did not receive any training on the air mattress. On 4/2/2026 at 9:54 AM, the surveyor interviewed LPN/NS #1 who stated that the air mattress should be adjusted according to the resident's weight. She added that it was important that the air mattress was set on the correct setting to prevent further skin breakdown, especially with these people that really do not have wounds.On 4/2/2026 at 1:39 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurses should check the setting on the air mattress every shift. She added that there should be a physician's order to check the settings every shift. She further added that the air mattress setting was based on the weight of the resident, and if there was a weight loss or gain, the setting would be adjusted. She further stated that ensuring that the air loss mattress setting was correct was important for their skin integrity.A review of the facility's Air Mattress (Pressure Redistribution Surface) policy, dated 5/1/2025, included, The facility shall provide pressure redistribution mattresses, including air mattresses, to residents as clinically indicated. All mattresses used in the facility shall meet New Jersey requirements for pressure redistribution capability. Air mattresses shall be used as part of a comprehensive skin integrity program and shall not replace required nursing interventions such as repositioning and skin care.PHYSICAN ORDER REQUIREMENTS: Type of mattress (alternating pressure, low air loss, etc.) .AIR MATTRESS SETTINGS A Weight-Based Adjustment Set mattress according to resident's weight per manufacturer guidelines . ONGOING MONITORING Verify mattress function and settings at least once per shift.NJAC 8:39-27.1 (a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review, it was determined that the facility failed to provide the necessary respiratory care and services for 1 of 2 residents (Resident # 16) reviewed. This deficient practice was evidenced by the following:A review of the admission Record (admission summary) indicated that Resident #16 was admitted to the facility with the diagnoses that included but was not limited to chronic obstructive pulmonary disease (COPD) and acute respiratory distress syndrome. A review of the quarterly Minimum Data Set (MDS), an assessment that facilitates a resident's care, dated 1/26/26, indicated that Resident #16 scored 14 out of 15 on the Basic Interview of Mental Status (BIMS) which indicated that the resident was cognitively intact. The MDS also indicated that Resident #16 was independent with all aspect of activities of daily living (ADLs). On 3/30/2026 at 11:29 AM, during initial tour, the surveyor was unable to observe Resident #16 in their room. Review of the Electronic Medical Record (EMR) revealed that the resident was on continuous oxygen (O2). The surveyor did not observe an oxygen concentrator (a medical device used for oxygen administration) or oxygen tank in the resident's room. A review of the physician Order Summary Report (OSR) reflected an order dated 10/25/2025 for continuous oxygen 3 liters a minute by way of nasal cannula (tube that delivers O2) every shift. On 3/31/2026 at 11:20 AM, the surveyor observed Resident #16 ambulating (walking) around the halls with a walker and the resident was not wearing O2. The surveyor again did not observe an O2 concentrator or O2 tank in the resident's room. On 4/1/2026 at 9:23 AM, the surveyor observed Resident #16 ambulating in the elevator and the resident did not wish to be interviewed. The resident was not wearing oxygen at that time. The surveyor went into the resident's room and did not observe an oxygen tank or concentrator available for use in the resident's room. A review of the Medication Administration Record (MAR) contained an order dated 10/25/2025 for continuous oxygen at 3L/min via (by way of) nasal cannula every shift and there were nursing signatures on each shift which indicated that the resident was administered continuous oxygen. On 4/1/2026 at 9:00 AM, the surveyor observed Resident #16 eating breakfast in their room. The surveyor observed that the resident was not on oxygen and there was no oxygen available in the room. The surveyor asked the resident the last time he/she remembered using oxygen and the resident stated that they had not used O2 in approximately 5 (five) months. The residents was adamant that they did not need oxygen. Resident #16 then stated that they did not know why the surveyor was asking these questions and got a little agitated. The conversation ended with the resident stating, I have not used oxygen and don't ask me about it again. On 4/1/2026 at 9:02 AM, the surveyor interviewed the Certified Nursing Assistant (CNA) who stated that the resident was pleasant, alert and oriented and ambulated with the use of a walker. She continued to explain that the resident only required supervision with ADLs (activities of daily living) and was continent of bladder and bowel. She revealed that the resident did use oxygen and that she had never seen the resident utilizing oxygen. She continued to add that she did not work other shifts and maybe the resident utilized it on those shifts. On 4/1/2026 at 9:07 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #16 was alert and oriented and could be verbally abusive if the resident did not get what they wanted. She also stated that the resident performed self-care and was non-complaint with taking medications. She explained that the resident had nebulizer treatments but refused at times. She further explained that if the resident wanted the oxygen, then they could use it but the resident was non-compliant with oxygen use most of the time. She stated that last week (did not provide a date) she offered the resident oxygen, but the resident refused it. She stated that she could not remember if there was oxygen available in the room. She stated that if a resident refused oxygen multiple times, then nursing should notify the physician and change the order for oxygen to prn (as needed). The LPN stated that if the resident refused the oxygen, then it should be documented as refused on the MAR. The LPN accompanied the surveyor to the resident's room and confirmed that there was no oxygen available in the resident's room. The LPN reviewed the MAR in the presence of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surveyor and confirmed that there were only 4 (four) times in the month of March that nursing documented that the resident refused the oxygen, 3/4/26 at 8:00 am, 3/6/26 at 8:00 am and 4:00 PM, 3/28/26 A review of the Interdisciplinary Care Plan (ICP) reflected a focus, dated 11/4/2025, that the resident had oxygen therapy related to (r/t) the diagnoses of COPD with interventions that included: Staff would monitor vital signs. There was no documentation in the ICP that the resident had a history of refusing O2. On 4/1/2026 at 10:41 AM, the surveyor interviewed the Director of Nursing (DON) who stated that if a resident was ordered continuous oxygen an oxygen concentrator should be present in the resident's room, and the resident should be receiving oxygen via nasal cannula. She stated that the resident might have taken the oxygen concentrator out of the room but did not have an explanation as to why. She also stated that if a resident was refusing O2 the nursing staff should have documented the refusal in the MAR and in the progress notes. She further explained that the nursing staff should have called the physician to get the order changed to an as needed order. She stated that she was not sure what happened but would talk to the resident. On 4/2/2026 at 1:36 PM, the surveyor interviewed the [NAME] President Clinical Services (VPCS) who explained that Resident #16 was refusing O2 and was not on the oxygen. He stated that the nurses should have discontinued the O2 order since the resident was not on the O2. He stated that the nursing staff should not have signed the O2 order in the MAR indicating that the resident was on oxygen when the resident was refusing. He further added that after reviewing the resident's vital signs record, the resident's pulse Ox was documented above 92% on room air and no harm came to the resident. The VPCS confirmed that the nurses should have discontinued the O2. A review of the facility policy Oxygen Use Policy dated 12/19/2025, indicated that the purpose was to ensure the safe, clinically appropriate, compliant use of oxygen therapy for residents in accordance with a licensed practitioner's order, with proper storage and handling of oxygen equipment in resident's rooms and incorporation of oxygen therapy into the resident's comprehensive care plan.NJAC 8:39-15.1(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, record review, and document review, it was determined that the facility failed to provide sufficient nursing staff to ensure all residents reached their highest practical wellbeing by failing to: a) provide timely incontinence care to 2 out of 8 residents (Resident #1 and #36) reviewed for Activities of Daily Living, and b) provide sufficient nursing staff for 4 of 4 weeks of staffing prior to the recertification survey date of 4/6/2026 . This deficient practice was evidenced by the following:On 4/2/2026 at 9:15 AM, the surveyor conducted an incontinence tour with Licensed Practical Nurse/Nursing Supervisor (LPN/NS) #1 on the third floor. Resident #36 was observed lying in bed. When Resident #36 was asked if their incontinence brief was clean and dry, they stated that it was wet and they needed to be changed. They added that they had been wet since 5 AM. They further stated that at 5 AM that morning, they asked their assigned Certified Nursing Assistant (CNA) to change them, but the CNA left the room and never returned to change them.At that time, with the resident's permission, LPN/NS #1 checked the resident's brief. The outer layer was noted with a blue line, which indicated that the resident's brief was wet. LPN/NS #1 opened the resident's brief and confirmed that it was soiled with urine. She then stated that she was going to inform the resident's CNA to change them. Resident #36 further stated that they used to get changed at 5 AM in the morning, but for the past week, they have not been changing them at that time. When asked what happens when they need to be changed between breakfast and lunch, they stated, Nothing happens.At that time, the LPN/NS #1 went to get a CNA to change Resident #36.On 4/2/2026 at 9:30 AM, the surveyor, accompanied by LPN/NS #1, and conducted another incontinence tour on the 1st floor Ventilation Unit. Resident #1 was observed resting in bed. When LPN/NS #1 removed the resident's sheet, a large amount of dark brown loose feces was observed protruding out of the resident's brief and onto both legs. The feces were noted to be dried around the perimeter.At 9:32 AM, immediately following the observation, the surveyor interviewed Certified Nursing Assistant (CNA) #1, who stated that she was about to give an unsampled resident a bath, but before she could bathe them, she had to get Resident #48 off the commode first. When asked about the last time Resident #1's brief was changed, she stated that the night person last changed Resident #1, and she had not changed the resident during her shift. She added that she would usually check all the residents between 9:00 AM to 9:30 AM to see if they were soiled. CNA #1 was informed that Resident #1 was soiled with feces. She stated that she was unable to change them right away because she was waiting for Resident #48 to finish on the commode, and she also had a resident waiting to be showered. She added that she was the only CNA assigned to that unit on that shift for that day. She also stated that if she went in to change Resident #1, she would have to leave the door closed and she would not be able to hear the call bell for Resident #48, who was on the commode. She added that Resident #1 was a heavy wetter and they needed to be checked more frequently. She also stated that she was the only CNA working on that unit and planned to check Resident #1 before she started the unsampled resident's bath, because she knew that it would take her a long time to give them a bath.At that time, LPN/NS #1 stated that she would ask a nurse for assistance with Resident #1 and ensure that they were changed.On 4/2/2026 at 9:46 AM, the surveyor further interviewed LPN/NS #1, who stated that the CNAs were responsible for doing their rounds at the beginning of each shift to make sure all the residents were clean and dry. She added that, if the resident was wet or soiled, her expectation was that the resident would get immediate attention, especially with the population of residents. LPN/NS #1 further stated that the residents on the ventilation unit required more frequent checks at a minimum of every hour because they could not use the call bell.On 4/2/2026 at 1:52 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #36.A review of the admission Record (an admission summary) revealed that the resident had diagnoses which included: paralytic gait (an abnormal walking pattern caused by muscle weakness or paralysis, typically resulting from (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurological conditions like strokes, spinal cord injuries, or nerve damage), communication deficit, and cardiac arrhythmias.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/28/2025, indicated that the resident had a Brief Interview for Mental Status score of 14 out of 15, which indicated the resident's cognition was intact. Further review of the MDS revealed that the resident required assistance with toileting and was frequently incontinent of urine and bowel.A review of the Individualized Comprehensive Care Plan (ICCP) included a focus area dated 7/2/2024, stating that the resident had bladder incontinence related to the disease process. Interventions included: assisting with toileting as needed and establishing voiding patterns.On 4/2/2026 at 2:30 PM, the surveyor reviewed the EMR for Resident #1.A review of the admission Record (an admission summary) revealed that the resident had diagnoses which included: dependence on a ventilator, pressure ulcer of the sacral region, and anxiety.A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 3/12/2026, revealed that Resident #1 was absent of spoken words, and their hearing and vision were highly impaired. The MDS further revealed that the resident was always incontinent of bowel and frequently incontinent of urine and was dependent on staff for all ADLs (activities of daily living).A review of the Individualized Comprehensive Care Plan (ICCP) did not include activities of daily living (ADLs).On 4/2/2026 at 1:25 PM, the surveyor interviewed the LNHA who stated there were a total of 10 residents on the vent unit. He stated that there should have been 2 (two) CNAs and a nurse or 2 (two) nurses and a CNA, for the ten residents.On 4/6/2026 at 9:43 AM, the surveyor interviewed the Director of Nursing (DON), who stated that the CNAs should be on top of their residents and needed to check the residents every couple of hours to ensure that they were clean and dry, especially the heavy wetters. She added that as soon as CNAs started their shift and before they leave, they must make sure that everyone was fresh for the next shift.A review of the facility's Activities of Daily Living (ADLs)/Maintain Abilities policy, dated 5/1/2025, included, .The facility will provide care and services for the following activities of daily living: A. Hygiene -bathing, dressing, grooming, and oral care.A review of the facility's Incontinence policy, dated 5/1/2025, included, It is the policy of the facility to ensure that the residents receive care and services to prevent the use of an indwelling catheter unless clinically necessary and promotes urinary continence of its residents in accordance with State and Federal Regulations.2. For the resident with urinary incontinence, based on the resident's comprehensive assessment, the facility will ensure that: .c. 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. 3. For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility will ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much bowel function as possible.2.) A review of the Nurse Staffing Report provided by the facility for the following weeks revealed:1. For the 2 weeks of Complaint staffing from 09/21/2025 to 10/04/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -09/21/25 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs.-09/22/25 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs.-09/23/25 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs.-09/24/25 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs.-09/25/25 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs.-09/26/25 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs.-09/27/25 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -09/28/25 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.-09/29/25 had 12 CNAs for 123 residents on the day shift, required at least 15 CNAs.-09/30/25 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs.-10/01/25 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs.-10/02/25 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs.-10/03/25 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs.-10/04/25 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. 2. For the 2 weeks of staffing prior to survey from 03/15/2026 to 03/28/2026, the facility was deficient in CNA (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at the Pines	29 North Vermont Ave Atlantic City, NJ 08401

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staffing for residents on 14 of 14 day shifts as follows: -03/15/26 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs.-03/16/26 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs.-03/17/26 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs.-03/18/26 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs.-03/19/26 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs.-03/20/26 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs.-03/21/26 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -03/22/26 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs.-03/23/26 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs.-03/24/26 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs.-03/25/26 had 12 CNAs for 131 residents on the day shift, required at least 16 CNAs.-03/26/26 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs.-03/27/26 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs.-03/28/26 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs.On 4/6/2026 at 12:01 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated they were doing a much better job with the staffing these days. He added that they used a staffing agency to cover and fill in the best they can for the open available shifts. He further stated that they hired a recruiting firm, and they worked directly with job sites. He confirmed that the facility was not meeting the ratios. He added that if there were not enough caretakers to meet the amount of care needed, the residents would be at risk for not being cared for. A review of the facility's Staffing policy, dated 5/1/2025, included: This policy ensures compliance with the current New Jersey mandates, rules, and regulations governing staffing in skilled nursing facilities. The goal is to provide adequate staffing for high-quality resident care and regulatory compliance.To comply with New Jersey's nursing home staffing law, Excelcare will make every effort to maintain the following minimum CNA ratios: Day Shift (7 AM- 3 PM): 1 CNA per 8 residents Evening Shift (3 PM - 11 PM): 1 CNA per 10 residents Overnight Shift (11 PM - 7 AM): 1 CNA per 14 Residents These staffing ratios must be maintained at all times.NJAC 8:39-5.1(a), 27.2(h)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interview, it was determined that the facility failed to ensure that the daily Nursing Home Resident Care Staffing Report was posted and displayed in the front lobby. This deficient practice was identified on 1 of 1 main entrance and was evidenced by the following: On 4/6/2026 at 10:15 AM, the surveyor observed the facility's Nursing Home Staffing Report Form dated 4/2/2026, posted on the receptionist's desk in the front main lobby. On 4/6/2026 at 10:20AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that he posts the schedule out front so that visitors and patients know what the staffing is like. He added that on Fridays, he preprints the staffing reports for Saturdays and Sundays and places them in the stand behind Friday's report. He further stated that the supervisor was responsible for posting the staffing report in his absence and adjusting it, if there were any call outs. He acknowledged that the daily staffing should be accurate and posted daily. A review of the facility's Staffing policy, dated 5/1/2025, failed to include any details that pertained to the required daily posting of the Nursing Home Resident Care Staffing Report. NJAC 8:39-41.2 (a)(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure 1.) a resident received a Renal-Regular Double Portions diet for a lunch meal in accordance with physician orders, and 2.) a resident received a Regular Diet with small portion starches, double portions of entree and vegetable; provide extra sandwich with lunch and dinner in accordance with physician orders. This deficient practice was identified for 2 of 3 residents reviewed for nutrition (Resident #7, #18). This deficient practice was evidenced by the following: 1.) On 3/30/2026 at 10:29 AM, during the initial tour, the surveyor observed Resident #18 lying in bed. Resident #18 had oxygen in place and stated to the surveyor that he/she did not feel well and stated, sick. On 3/31/2026 at 10:53 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #18. A review of the admission Record revealed that Resident #18 was admitted to the facility with the following but not limited to diagnoses: Anemia, acute respiratory failure, iron deficiency, dependence on renal (kidney) dialysis, and end stage renal disease (ESRD). A review of Resident #18's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/26/2026, included the resident had a Brief Interview for Mental Status (BIMS) score of 11/15, which indicated moderate cognitive impairment. Further review of the MDS revealed at Section GG that Resident #18 ate independently. Section K revealed that Resident #18 received a therapeutic diet and Section O revealed that Resident #18 received hemodialysis (a life sustaining treatment for kidney failure) while a resident at the facility. A review of Resident #18's individual comprehensive care plan (ICCP) included a Focus area, date initiated: 3/30/2026 and revision date: 3/31/2026, that Resident #18 was at risk for malnutrition r/t (related to) need of therapeutic diet, hypermetabolism (a state of extremely rapid metabolism where the body requires significantly more energy at rest, often leading to involuntary weight loss), receives hemodialysis, low BMI (body mass index) for advanced age, Hx (history of) significant weight changes, PMHx (past medical history) ESRD, Anemia, ASHD (atherosclerotic heart disease), malignant neoplasm of colon (colon cancer), HTN (hypertension), pure hypercholesterolemia and T2DM (type 2 diabetes mellitus). Interventions included: Provide, serve diet as ordered. Monitor intake and record q (every) meal. Renal diet, Regular texture, thin consistency-Double Portions. Date Initiated: 2/27/2026 and Revision on: 3/3/2026. A review of the Order Summary Report (OSR), dated as of 4/6/2026, included the following physician's orders (PO): A PO, dated 2/27/2026, for Renal Diet Regular texture, Regular/Thin consistency, double portions. On 4/1/2026 at 12:58 PM, Resident #18 was observed lying in bed and attempting to sleep. The lunch tray was observed on the over the bed table next to the resident's bed. Resident #18 received the following diet per the meal ticket on the lunch meal tray: Renal-Regular. Double portions. The surveyor observed the following menu items on the meal tray: (1) chicken breast, green beans, applesauce in a 4-ounce (oz) portion control cup with a clear plastic lid, 4 oz juice, coffee 6oz, sugar packet x 2 and pepper x 1. Resident #18 consumed 1 (one) bite of chicken breast, an unknown quantity of green (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	beans (approximately 10% of 4 oz), 0% applesauce, and 0% coffee. According to the meal ticket Resident #18 was to receive the following food items at the lunch meal: Baked Chicken - 6 oz, [NAME] - 1 cup, Mixed Vegetable - 4 oz, Tropical Fruit Cup - 1/2 cup, Juice, No Orange - 4 oz, Hot Coffee - 6 oz, Reg Sugar - 2 Pkg (package) and Pepper 1 Pkg. Resident #18 was observed to receive 1 chicken breast, and about 1/2 cup of green beans on their plate. There was no rice provided on the plate at the lunch meal. Resident #18 stated that he/she received rice all the time and did not know why it was not received at this meal. On 4/1/2026 at 1:13 PM, the surveyor conducted an interview with the facility Director of Dietary (DD). The surveyor asked the DD during the tray line (meal assembly) process if there was a person responsible for ensuring meal accuracy. The DD told the surveyor that the checker at the end of the tray line ensures tray accuracy according to the resident's meal ticket. The surveyor presented Resident #18's lunch meal ticket to the DD and asked him what Resident #18 should have received on his/her lunch meal tray. The DD told the surveyor that Resident #18 should have received 6 oz of chicken, and a double serving of green beans because the ticket said double portions. The DD further stated that Resident #18 should have received double servings of green beans and double chicken. The surveyor then asked the DD if Resident #18 should have received rice at the lunch meal. The DD told the surveyor that Resident #18 should have gotten everything on the ticket. The surveyor asked the DD if they had rice available at the lunch meal and the DD stated, Yes, we have rice. The DD further stated that Resident #18 only received one (1) chicken breast at lunch because the box that the chicken was received in stated they were 4-6 oz portions. The surveyor asked the DD if they weighed the chicken after cooking and prior to plating to ensure that it was at least 6 oz. The DD stated, No, nobody weighs the chicken prior to plating to determine if it was 6 oz. 2.) On 3/31/2026 at 12:17 PM, the surveyor observed Resident #7 lying in bed awake. When interviewed the resident stated that he/she was supposed to have received double portions according to the dietician but they were not received. On 3/31/26 at 10:29 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #7. A review of the admission Record, (an admission summary) revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; multiple fractures of pelvis (the large bony structure near the base of the spine to which the legs are attached) with stable disruption of the pelvic ring, initial encounter for closed fracture, unspecified fracture of shaft of unspecified tibia (the larger of the two bones between the knee and the ankle), initial encounter for closed fracture, fracture of unspecified part of left clavicle (collar bone), subsequent encounter for fracture with delayed healing, difficulty in walking, and muscle weakness (generalized). A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 1/8/2026, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Further review of the MDS revealed that the resident had no identified weight loss. A review of the resident's Care Plan Report revealed a focus area dated 1/5/2026, which indicated that the resident was at risk for malnutrition related to altered nutrition, labs, need of therapeutic diet, varied PO (oral) intake, low BMI (Body Mass Index) for advance age. Past Medical History: HTN (hypertension, high blood pressure), CKD 3 (Stage three kidney disease). Interventions included: .Regular diet, Regular texture, Thin consistency small portion starches, double portion entrees, double (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	portion vegetables, provide extra sandwich with lunch and dinner. RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). A review of the Order Summary Report dated as of April 2, 2026, included the following physician's order (PO): -A PO, dated 1/13/2026, for Regular texture, regular/thin constancy, small portion starches, double portion entrée and vegetables; provide extra sandwich with lunch and dinner. On 4/2/2026 at 11:43 AM, the surveyor observed Resident #7's breakfast meal ticket which consisted of a Vegetable Frittata - 1 square, Cream of [NAME] Cereal - 6oz, Biscuit - 1 ea., 1 butter, Jelly - 1ea, Hot Coffee - 6oz, Juice of Choice - 4oz, Banana - 1ea, Reg Sugar 2 pkg, 2% Milk 8oz - 1ea. The ticket was dated 4/2/2026 Thursday Breakfast. The surveyor observed Resident #7's meal tray which revealed that Resident #7 received one serving of Vegetable Frittata, one banana, one serving of Cream of [NAME] cereal, one 4 oz juice and one biscuit. There were no double portions provided on this observation. On 4/2/2026 at 10:20 AM, the surveyor interviewed the Registered Dietician (RD) who stated that he had reviewed Resident #7's preferences upon admission and the resident had no dislikes to report. The RD stated that the resident was ordered a Regular texture, Regular/Thin consistency, small portion starches, double portion entrée and vegetables; provide extra sandwich with lunch and dinner diet. The RD stated when there was an order update he sent out an email to the Director of Nursing (DON) and the Food Service Director (FSD) and the nursing staff would provide the diet slip to the kitchen once the order were approved by the doctor. The RD stated that the diet slips were supposed to be done. The RD further stated that the FSD had been here since January, and he would have expected double portions to come up on the resident's meal ticket and meal tray. On 4/2/2026 at 10:55 AM, the surveyor interviewed the Director of Dietary (DD) who stated that when double portions were requested via a physician's order they should connect automatically through the facility's meal tracker system. The DD stated that double portions should absolutely have been listed on the resident's meal ticket in accordance with the physician's order. The DD stated that he was not here when the resident was admitted to the facility. On 4/2/2026 at 12:13 PM, in a later interview with the DD, he stated that he reviewed the meal tracker system and had nothing on record for Resident #7 to identify that the resident was ordered double portions. The surveyor then proceeded to review the physician's order with the DD, and he stated that he would follow-up later. On 4/2/2026 at 12:21 PM, the surveyor interviewed Licensed Practical Nurse (LPN #2) who stated that if a dietary order were placed by the RD and was pending, she would call the doctor to confirm and obtain a dietary order. LPN #2 stated then she would complete a dietary slip and take it down to the kitchen, and a carbon copy was maintained in the resident's paper chart. The surveyor then asked LPN #2 to review Resident #7's paper chart to look for documented evidence of dietary slip completion to reflect that the resident was ordered double portions in accordance with the physician's order and LPN #2 confirmed that a dietary slip was not found within the resident's paper chart to indicate that it had been completed and copied before being delivered to the dietary department to be processed. On 4/2/2026 at 12:36 PM, the surveyor interviewed the [NAME] President Clinical Services (VPCS) (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who stated that the assigned nurse who confirmed the order, was responsible to complete a dietary slip, then put a copy on the resident's chart, and take a copy to the kitchen. The VPCS stated that the dietary order should have become effective once it was confirmed by the nurse on 1/15/2026. On 4/2/2026 at 1:25 PM, the Licensed Nursing Home Administrator (LNHA) was made aware that Resident #7 had not received double portions in accordance with the physician's order. On 4/6/2026 at 12:01 PM, in the presence of the survey team, the VPCS stated that the RD had an obligation to ensure that his recommendations were addressed for Resident #7. The surveyor requested to speak with the RD at that time, but the RD was not available for interview. A review of the facility Tray Accuracy Policy dated 5/1/2025, included: To assist in setting up and serving the correct food trays/diets to residents, the Food services Department shall use appropriate identification (e.g., color coded or computer-generated diet cards) to identify the various diets. The Food Services Manager or supervisor shall check trays for correct diets before the food carts are transported to their designated area. Nursing staff shall check each food tray for the correct diet before serving the residents. If there is an error, the Nurse Supervisor shall notify the Dietary Department immediately by phone so that the appropriate food tray can be served. NJAC 8:39-17.4(a)(1)