STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at Dover	65 North Sussex Street Dover, NJ 07801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** 41072 Complaint # NJ157563 Based on observation, interview, and review of facility documentation, it was determined the facility failed to maintain a comfortable and homelike environment for resident rooms on one (1) of six (6) nursing units of the facility observed (2nd floor Unit). The evidence of this deficient practice includes: On 5/23/24 at 10:28 AM, during the initial tour of the 2nd floor Unit, the surveyor observed the following: room [ROOM NUMBER] and room [ROOM NUMBER]- Noticeable odor of wet carpet and urine in room room [ROOM NUMBER]-carpets in room visibly frayed room [ROOM NUMBER]-carpets in room were visibly frayed and stained. room [ROOM NUMBER]- large black stain observed between door and window bed. On 5/28/24 at 12:28 PM, the surveyor observed the following on the 2nd Floor Unit: room [ROOM NUMBER] and room [ROOM NUMBER]-odor of wet carpet and urine remained. room [ROOM NUMBER] and 218- carpets remained frayed and stained. On 5/29/24 at 10:06 AM, during a follow-up tour of the 2nd floor Unit, the surveyor observed the following: room [ROOM NUMBER]- carpet frayed at door entrance, room to hallway transition strip missing, room odor remained. room [ROOM NUMBER]- carpet ripped/frayed, odor remained. room [ROOM NUMBER]- carpet frayed, stained black. (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: 315355	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024
NAME OF PROVIDER OR SUPPLIER Excel Care at Dover		STREET ADDRESS, CITY, STATE, ZIP CODE 65 North Sussex Street Dover, NJ 07801	

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room [ROOM NUMBER]- carpet in front of door ripped/frayed. room [ROOM NUMBER]- carpet at entrance of room ripped/frayed, room to hallway transition strip is missing. room [ROOM NUMBER] - carpet by B bed ripped/frayed, room to hallway transition strip missing, carpet near bathroom was stained. room [ROOM NUMBER]- carpet ripped in 2 areas in between the beds. room [ROOM NUMBER]- carpet Stained On 5/29/24 at 10:16 AM, the surveyor interviewed the Director of Maintenance, (DM) who stated that he does environmental rounds such as checking hot water temperatures. The DM further stated that he was just starting to do daily environmental rounds with the housekeeping (HK) department. On that same date and time, the DM stated that he was aware that the carpets in room [ROOM NUMBER] and room [ROOM NUMBER] were wet because the toilet had overflowed into the two carpeted rooms on 5/21/23. The DM stated that when a staff member finds something broken or needing repair, the staff will write it in the Daily Maintenance Log book. When he does his daily rounds, he will check the book and initial next to the room number then he will put in a work order. If it was an emergency repair, the staff will then page him. On 5/29/24 at 12:28 PM, the surveyor reviewed the above carpet and room concerns with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), [NAME] President of Risk Management (VPoRM), and [NAME] President of Clinical Services (VPoCS). The LNHA stated that the maintenance department conducts environmental rounds, and the HK department conducts cleaning rounds. The surveyor requested any documentation of the environmental and HK audits or rounding. A review of the April and May 2024 Daily Maintenance Log binder, located at the 2nd floor Nurses Station, did not reveal any entries regarding the condition of the carpets. On 5/30/24 at 10:42 AM, the surveyor interviewed the Director of Housekeeping (DH) who stated that every day he does environmental rounding of the whole building. He further stated that he does random rooms and checks the carpets, wheelchairs, curtains, blinds, etc. If something was broken or needed repair, he would report it to maintenance. The DH stated that any maintenance repairs observed during the rounds would be told to maintenance verbally and that he did not write it in the maintenance log. The DM further stated that he was aware that the carpets in Rooms 215 and room [ROOM NUMBER] were wet and had an odor because the toilet had overflowed. He stated that the carpets were cleaned with a shampoo machine. The surveyor reviewed the random audits provided by the DH and there was no documentation of the frayed or stained rugs and that the maintenance department was notified. On 5/30/24 at 12:02 PM, the administrator stated that he did environmental rounds with the maintenance dept weekly but was unable to provide any documentation or maintenance audits. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy Resident Right-Safe/Clean/Comfortable/Homelike Environment dated 5/01/2024, revealed that the facility will provide a safe, clean, comfortable, homelike environment such a manner to acknowledge and respect residents' rights. The resident has a right to a safe, clean, comfortable, and homelike environment. NJAC 8:39-4.1(a) 11, 31.4(a)

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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 Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 31654 Complaint #NJ171307 Based on interview, record review and review of pertinent documents, it was determined that the facility failed to develop comprehensive policies and consistently implement procedures to prevent and investigate abuse by failing to ensure: a) a system was in place to pre-screen contracted staff timely and provide training on the current facility abuse policies, b) all residents who may have been abused were identified and a documented system was in place to rule out abuse, c) all involved persons, including potential witnesses, were identified, and a documented interview was completed per facility policy, and d) a system was in place to ensure a complete and thorough investigation occurred and was documented. This deficient practice occurred for two (2) of two (2) residents (Resident #42 and #85) who alleged sexual abuse by a contracted certified nurse aide. This deficient practice was evidenced by the following: Refer to 610F On 5/22/24 at 10:40 AM, the Licensed Nursing Home Administrator (LNHA) provided the survey team with the Abuse Prohibition Policy and Procedures that was required as part of the entrance documents provided by the facility. The unsigned document, contained 19 unnumbered pages, included, but was not limited to the following: -Freedom from Abuse, Neglect, and Exploitation Policy/Procedure, dated 6/01/23. Intent: The facility will develop and operationalize policies and procedures for screening and training employees, protection of residents and for the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property; to include the use of physical and or chemical restraints. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences. Procedure: This policy will include: 1. Free from Abuse and Neglect. 2. Free from Misappropriation/Exploitation. 3. Free from Involuntary Seclusion. 4. Right to be Free from Physical Restraints. 5. Right to be Free from Chemical Restraints. 6. Not Employ/Engage Staff with Adverse Actions. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	7. Develop/Implement Abuse/Neglect, etc. Policies. 8. Reporting of Reasonable Suspicion of a Crime. 9. Reporting of Alleged Violations. 10. Investigate/Prevent/Correct Alleged Violation. -The next page revealed Subject: Freedom from Abuse, Neglect, Misappropriation, Exploitation with the same Intent. Procedure: 1. The resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, or involuntary seclusion. [The remainder of the page was left blank and there was no documented process or procedure]. -Another page revealed the Subject: Freedom from Abuse, Neglect, etc. and had the same Intent. Procedure: 1. The facility will develop and implement written and policies and procedures that: a. Prohibit and prevent abuse, neglect, and exploitation of resident and misappropriate of resident property. b. Establish policies and procedures to investigate any such allegations, and c. Include training. [The remainder of the page was left blank and there was no documented process or procedure]. -Another page revealed the Subject: Reporting of Reasonable Suspicion of a Crime and Alleged Violations and had the same Intent. Procedure: . 4. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility will: a. Have evidence that all alleged violations are thoroughly investigated. b. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. c. Report the results of all investigation to the administrator or his or her designated representative and to other officials in accordance with State Law . 9. The facility Risk Manager or Designee will be responsible for the Form completion when a staff member does not complete one and will also be responsible for the investigation and documentation of final findings. The document did not specify procedures to follow to screen contracted employees, educate contracted employees, identify, and protect other residents that may have been abused when an allegation of abuse was made, and what specific procedures were to be followed to conduct a thorough investigation. A review of a Reportable Event Record (RER) that had been submitted to the Department of Health (DOH) by the facility Director of Nursing (DON) on 02/09/24 at 12:34 PM revealed: Type of Incident: Staff- to- Resident Abuse. (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Narrative: Resident #85 stated private part was washed roughly by the nursing assistant who got him/her ready for bed on Saturday evening 02/03/24. Resident #85 stated heard Resident #42, speaking in a foreign language and stated the same thing and that's why he/she reported this issue today 02/08/24. Resident #42, upon interview [untimed] stated that during care a few days ago, a [color] male nursing assistant with curly hair entered the room, took the resident do the bathroom and put his mouth on [genital organ]. What interventions were implemented after the incident: Both residents were interviewed and total body assessment were completed immediately. Family and physicians were notified. Police Department was notified. Investigation on going. The undated Investigation Summary submitted by the facility revealed: Investigation: On 02/08/24, Resident #85 reported to the nurse on duty, that he/she did not like the way the male nursing assistant who provided care on Saturday evening and washed his/her private part. The nurse informed the DON who went to further interview Resident #85. Resident #85 stated that on 02/03/24 the aide was washing his/her private area kind of in a rough manner. Resident #85 stated that on 02/03/24, heard Resident #42 talking in a [foreign language] in the hallway about the same thing. DON and a [foreign language] speaking staff interviewed Resident #42. Resident #42 explained maybe two nights before, around midnight, a male went into his/her room, led to the bathroom and while in the bathroom, the aide put his mouth on his/her [genital organ]. Resident #42 stated that he/she told his/her family member (FM). About the incident. The DON placed a call to the FM. The involved Certified Nurse Aide (CNA) was interviewed and denied the accusation. The CNA stated he was assisting Resident #42 to the toilet when the FM arrived at the floor, the CNA left when FM entered the room. Both patients were interviewed by the Police. The roommate of Resident # 85 was present in the room during all interactions and denied seeing or hearing any incidents. Both Residents had complete skin assessment and no injuries noted. Summary/Conclusion: -The Allegation was Unsubstantiated. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	-According to the staff, Resident #42's FM visited right when the CNA was with Resident #42 and entered the room before the CNA left. -The CNA stated he only assisted the patient at that time before his/her FM visited and that the FM met the CNA in the bathroom with the resident when he was sitting Resident #42 down on the toilet and left the resident in the care of the FM. - All alert and oriented patients on the unit who were cared for by the employee were interviewed and did not report any concerns. Interventions: -Both Resident #42 and #85 were educated on reporting incidents immediately. -FM was educated on reporting incidents regardless of the patients' cognition or description of the incident. -Both patients were assessed, complete body assessment was done with no abnormalities noted. -Both patients were referred for psychology consult for emotional support. -Incident reported to the Ombudsman. -The employee was an agency staff; he was suspended immediately pending the investigation and will not return. On 5/23/24 at 10:30 AM, the surveyor reviewed the electronic Medical Record (eMR) for Resident #85 as follows: The Admission Record (AR, or face sheet, an admission summary) revealed diagnoses which included, but were not limited to; type 2 diabetes, Parkinson's Disease and major depressive disorder. A review of the 22-page current Care Plan (CP) with a target date of 7/19/24 and including resolved items, did not reveal a Focus related to the allegation of sexual abuse that occurred on 02/03/24 and was reported on 02/08/24. The multi-disciplinary progress notes (PN) from 01/29/24 through 02/26/24 did not show a nurses note or physician documentation related to the allegation of sexual abuse that occurred on 02/03/24 and was reported on 02/08/24. A physical, psychosocial or any other type of assessment related to the allegation of sexual abuse was not located in the eMR or paper medical record. The most recent Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, indicated the resident scored a 14/15 on the brief interview for mental status (BIMS) which indicated the resident was cognitively intact. A review of Resident #42's EMR showed the following: (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 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Note: The nursing home is disputing this citation.

The AR had diagnoses that included, but were not limited to, major depression disorder and unspecified dementia.

The current 21-Page CP, including resolved items, and had a target date of 6/07/24, did not show a Focus related to the allegation of sexual abuse that occurred on 02/03/24 and was reported on 02/08/24.

Reviewed all interdisciplinary PN from 02/02/24 through 02/20/24 which did not reveal a nurses note or physician documentation related to the allegation of sexual abuse that occurred on 02/03/24 and was reported on 02/08/24. A physical, psychosocial or any other type of assessment related to the allegation of sexual abuse was not located in the eMR or paper medical record.

A review of the most recent Quarterly MDS indicated the resident scored a 9/15 on the BIMS which indicated the resident was moderately cognitively impaired.

On 5/28/24 at 9:20 AM, the [NAME] President of Risk Management (VPoRM) provided the surveyor with what he stated was the completed facility investigation and provided the RER. The surveyor then requested all documents from the DON, in the presence of the VPoRM regarding statements and any investigative documents reviewed. The DON pointed to her type-written summary and stated, those were the statements.

On 5/28/24 at 10:30 AM, the surveyor asked the Licensed Nursing Home Administrator (LNHA) what the process was regarding hiring agency staff and educating them on abuse. The LNHA stated, the agency staff had an orientation and was in-serviced by the DON and the process was the same as for a new employee. The process was the same for all new employees and stated was not sure of the process. The surveyor asked if the abuse policy that was provided was the only facility abuse policy and the LNHA stated he will look for any other specific abuse policy.

On 5/28/24 at 11:10 AM, the surveyor interviewed the Director of Social Services (DSS) who stated she had been at the facility for three months. She stated she was the Grievance Officer. The surveyor asked what the protocol for abuse was. She stated if she received an allegation of abuse she would inform the LNHA and DON. She stated she interviewed residents and family and would document in the grievance book.

At that same time, the surveyor asked the DSS if she had a grievance for abuse from Resident #85 and #42 and she stated, not that she was aware of. The surveyor asked what constituted abuse and the DSS stated if a resident felt they were touched inappropriately, or any signs of bruises that she would interview the resident and anyone involved. The surveyor asked if there was a process for the investigation and she stated she would look for it.

On 5/28/24 at 11:32 AM, the survey team met with the LNHA, DON, [NAME] President of Clinical Services (VPoCS) and VPoRM. The surveyor asked if there was anything that was provided as guidance to staff regarding what was supposed to completed when an allegation of abuse occurred. At that time, when asked about the investigation related to Resident #85 and #42, the DON confirmed there were no other individual statements taken from any other residents. The LNHA then confirmed he did not review the investigation as he was not at the facility during that time.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 Note: The nursing home is disputing this citation.	A review of the facility provided investigation revealed there were two statements attached, one untimed statement from the accused CNA, dated 02/08/24 and another document with a typed statement, undated and untimed. There were no assessments, interviews from other staff, residents, the FM or any of the alleged documents referenced per the RER, and there were no attached police reports. The education for the CNA that was attached to the facility provided investigation included a copy of an abuse policy from a completely different facility located in another town and did not have the same company name. On 5/28/24 at 01:01 PM, the VPoRM provided a second abuse policy titled, Abuse Investigation and Reporting Policy, dated 5/01/24 which included: Intent: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Procedure: Role of the Administrator 1. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will suspend immediately any employee who has been accursed of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. Role of the Investigator: The individual conducting the investigation will, as a minimum. -Review the completed documentation forms. -Review the resident's medical record to determine events leading up to the incident. - Interview the person(s) reporting the incident. - Interview the resident. -Interview other residents to who the accused employee provides care or services. - Interview the residents's roommate, family members, and visitors. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	The following guidelines will be used when conducting interviews: . -Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. On 5/29/24 at 12:52 PM, the above concerns were shared with the LNHA, DON, VPoCS and VPoRM and there was no additional information provided during the exit conference held on 05/31/24 at 11:56 AM. NJAC 8:39-4.1(a)5

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Complaint #NJ171307 #NJ164582 45449 Based on observations, interviews, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to report as required to the New Jersey Department of Health (NJDOH) within two hours: a) an allegation of sexual abuse that occurred for two residents by a staff member, b.) an injury of unknown origin, and c.) an allegation of abuse. This deficient practice occurred for four (4) of six (6) residents reviewed for abuse (Residents #35, #42, #85, and #104) and was evidenced by the following: Refer to 610F 1. Surveyor#1 (S#1) reviewed a Reportable Event Record (RER) confirmation sheet that indicated the RER was submitted to the NJDOH by the facility Director of Nursing (DON) on 02/09/24 at 12:34 PM (one day after the incidents were reported). The RER revealed: Today's date: 02/08/24 Date of Event: 02/08/24 Time of Event: 6:30 PM Was this a significant event? Yes. Type of Incident: Staff- to- Resident Abuse. Narrative: Resident #85 stated private part was washed roughly by the nursing assistant who got him/her ready for bed on Saturday evening 02/03/24. Resident #85 stated heard Resident #42, speaking in a foreign language and stated the same thing and that's why he/she reported this issue today 02/08/24. Resident #42, upon interview [untimed] stated that during care a few days ago, a [color] male nursing assistant with curly hair entered the room, took the resident do the bathroom and put his mouth on [genital organ]. The undated Investigation Summary submitted by the facility revealed: Investigation: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/08/24, Resident #85 reported to the nurse on duty, that the resident did not like the way the male nursing assistant who provided care on Saturday evening and washed his/her private part. The nurse informed the DON who went to further interview Resident #85. Resident #85 stated that on 02/03/24 the aide was washing his/her private area kind of in a rough manner. Resident #85 stated that on 02/03/24, heard Resident #42 talking in a [foreign language] in the hallway about the same thing. When Resident #85 was asked why did not report the incident sooner, resident stated it had been on resident's mind to report it but he/she did not. Resident #42 explained maybe two nights before, around midnight, a male went into his/her room, led the resident to the bathroom and while in the bathroom, the aide put his mouth on his/her [genital organ]. On 5/28/24 at 01:06 PM, the [NAME] President of Risk Management (VPoRM) provided S#1 with and Abuse Investigation and Reporting Policy. On 5/30/24 at 10:30 AM, the facility met with the survey team and did not provided any additional information regarding the delay in reporting for the allegations of sexual abuse. 2. On 5/23/24 at 9:32 AM, S#2 received information from S#3 that Resident #104 reported to S#3 that he/she was hit by a staff about a year ago. On 5/23/24 at 9:35 AM, during a meeting with the Licensed Nursing Home Administrator (LNHA) and the DON, S#2 discussed the information received by the surveyor regarding Resident #104's allegation that a staff had hit the resident. At that time, the LNHA stated, We will start the investigation right now. At that time, the DON stated, We will report to the state agency and the Ombudsman. According to the Admission Record (AR, an admission summary) Resident #104 had diagnoses which included, but were not limited to, dementia and Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks). A review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 3/05/24, included the resident had a Brief Interview for Mental Status score of 12 out of 15 which indicated the resident's cognition was moderately impaired. It included that the resident had no signs or symptoms of delirium. The resident's individualized care plan reflected a focus that the resident had an activities of daily living deficit, initiated on 02/28/24 .The interventions included maximum assistance for bathing, showering, bed mobility, dressing eating, personal hygiene. Additionally, the resident required skin inspections for redness, open areas, scratches, cuts, bruises and for changes to be reported to the nurse. A review of Resident #104's skin evaluations revealed the following: -On 3/25/24, right forearm, skin tear was documented without pain (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Excel Care at Dover		STREET ADDRESS, CITY, STATE, ZIP CODE 65 North Sussex Street Dover, NJ 07801	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 4/08/24, left posterior hand, skin tear was documented without pain -On 4/15/24, left posterior hand, skin tear was documented without pain -On 4/22/24, left posterior hand, skin tear was documented without pain -On 4/29/24, left posterior hand, skin tear was documented without pain -On 5/06/24, no skin issues, were documented -On 5/13/24, no skin issues, were documented -On 5/27/24, no skin issues, were documented A review of the facility provided Investigation Summary and Conclusion reflected the Director of Social Services (DSS) interviewed the resident, a resident statement made to the DON and a skin assessment was conducted with no findings. The Witness Statements revealed the following: -Review of the statement from the DSS dated 5/23/24, reflected that the resident reported to the DSS that a short haired [color] male registered nurse banged the resident's knees into the wall in the bathroom. -Review of the statement from the Registered Nurse dated 5/23/24 at 9:45 AM, reflected that the resident stated he/she was hit. The resident was noted to be forgetful, oriented to self and place, no apparent injuries, was able to move all extremities with no difficulties. A fading discoloration noted to bilateral (both) knees. -Review of the statement from the DON dated 5/23/24 reflected that when she had entered the room the full body assessment was in progress. The resident stated to the DON that he/she ran into the wall by a short white [color] while walking in resident's room and the incident occurred in September 1998. The DON's documentation also reflected that the responsible party (RP) of the resident did not believe the incident was true. On 5/29/24 at 12:52 PM, in the presence of the survey team, the [NAME] President of Clinical Services (VPoCS), the VPoRM, the LNHA and the DON, S#2 discussed the concern regarding the facility's abuse investigation process for Resident #104's injury of unknown origin. There was no evidence provided that the facility reported to the State Agency within the two (2) hour time frame upon discovery. On 5/30/24 at 9:41 AM, in the presence of S#2, and the [NAME] President of Clinical Services (VPoCS), the DON stated that the allegation of staff to resident abuse was reported to the State Agency and the Ombudsman. At that time, the DON submitted a copy of the RER that indicated the event was called in on 5/23/24 at 10:00 AM and was reported as a staff to resident abuse. (continued on next page)

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F 0609

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Further review of the RER reflected the resident alleged that the resident was hit by a nurse and could not identify the nurse. The resident stated it might have been a short [color] male. The incident occurred in the bathroom, while in the chair, then while walking and that the incident occurred in 1998.

At that time, the DON stated that the allegation was unsubstantiated for the staff to resident abuse since there were no short haired [color] male nurses.

At that same time, S#2 asked the DON if there were any other information associated with Resident #104's faded discoloration noted to bilateral knees. The DON stated that the staff to resident abuse was unsubstantiated, while the investigation for the faded bruising continued. The incidents were delineated which was the reason it was not mentioned in the summary and conclusion provided.

On 5/30/24 at 12:02 PM, in the presence of the survey team, the VPoCS, the VPoRM, and the LNHA, the DON stated that the resident had narrated three (3) different stories. The DON stated she had unsubstantiated the part of that a man had pushed the resident and was still investigating the bruise on the resident's knees.

At that time, the DON provided three additional statements that were related to the bruising investigation. The DON confirmed the investigation for the bruises had not concluded.

On 5/31/24 at 9:54 AM, in the presence of the survey team, the surveyor gave the VPoCS, the VPoRM, the LNHA, and the DON an opportunity to submit additional information. No additional information was provided.

48422

3. On 5/23/24 at 10:13 AM, S#4 observed Resident #35 sleeping in their wheelchair with his/her head resting on the bedside table with a pillow.

A review of the resident's most recent quarterly MDS dated [DATE] reflected that the resident had a BIMS score of 15 out of 15 indicating intact cognition.

A review of the Grievance/Complaint Investigation Report dated 5/24/23 revealed Resident #35 filed a grievance with the Assistant Director of Nursing (ADON). The section referencing to documentation of grievance/complaint, documentation of facility follow up and resolution of grievance/complaint read as followed:

-Describe concern briefly using factual terms: (attach resident/family concern form)?

The resident reported he/she was removed from the food committee group meeting by the Director of Activities (DA) when she asked to postpone the meeting when other departments could be present. Resident did not appreciate being spoken to in the matter he/she was.

-What other action to resolve concern (be specific)?

(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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. 27193 Complaint #NJ164582, NJ169759, and NJ171307 Based on observations, interviews, record review and review of other facility pertinent documents, it was determined the the facility failed to complete and document a thorough investigation: a) to determine the origin for bilateral bruises to a resident's (Resident #6) arms, b) after receiving an allegation of two residents who were sexually abused by a staff member (Resident #42 and Resident #85), and c) an allegation of physical abuse (Resident #35). This deficient practice was identified for four (4) of four (4) residents reviewed for abuse and evidenced by the following: 1. On 5/21/24 at 10:15 AM, the surveyor observed Resident #6 in bed. The resident informed the surveyor that resident had an issue that he/she would like to discuss after breakfast. On that same date at 11:05 AM, the surveyor returned to Resident #6's room. The resident explained to the surveyor that he/she had some bruises to the bilateral arms that the resident obtained during blood drawn. The resident stated that the laboratory (lab) technician had Certified Nursing Assistant #1 (CNA#1) holding the resident's down for blood work on 5/06/24. Resident #6 further stated that he/she attempted to explain that he/she had blood drawn on 5/03/24 and would like to know why blood work had to be drawn again the morning of 5/06/24. Instead of providing the rationale for the blood work, the lab technician ordered the CNA to hold the resident down for the blood work. Furthermore, the resident stated that the Registered Nurse (RN) on duty that day heard them screaming and was mad at them for screaming. The RN did not explain why blood had be drawn this morning again on 5/06/24. Resident #6 stated that he/she was frustrated, upset and all bruised and sore, and the resident reported the incident. Resident #6 further stated that the resident had been on Eliquis (a blood thinner) and never had this issue before. The surveyor reviewed the medical record of Resident #6. The Admission Record (AR, or face sheet, an admission summary) indicated that Resident #6 was admitted to the facility with diagnoses which included, but were not limited to chronic kidney disease, difficulty in walking, need for assistance with personal care. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 02/09/24 revealed that Resident #6 had a Brief Interview for Mental Status (BIMS) score 11 out of 15 indicative of moderate cognitive impairment. The MDS of the resident showed that the resident was able to make his/her needs known. The comprehensive Care Plan (CP) with a Focus for potential impairment in skin integrity was initiated on 5/16/24. The CP did not have a Focus which indicated that the resident was combative with care and staff needed to hold the hands down for blood work. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the nurses's progress notes (PN) dated 5/07/24 timed 6:35 PM. The RN documented: Noticed bruises on bilateral arms of the resident. Left Arm: 14 centimeter (cm) x 8 cm. Right arm: 9 cm x 6 cm. Dark purplish in color. Not in pain. Mild swelling on right arm. No changes in Range of Motion (ROM). Resident said, It probably happen during lab drawn yesterday referring to 5/06/24 and a CNA was assisting to stabilize the arms. Resident Representative and Nurse Practitioner (NP) made aware. On 5/21/24 at 11:50 AM, the surveyor interviewed the RN who wrote the progress note dated 5/07/24. The nurse confirmed that he noted the bruises,took pictures, measured the bruises and generated the incident report. The RN stated that the incident was reported to the administrative staff. On 5/23/24 at 11:14 AM, during an interview with the CNA involved with the incident, she revealed that Resident#6 gets frustrated at times but was not combative with care. On 5/23/24 at 11:30 AM, the surveyor requested the investigation for review. On 5/23/24 at 12:50 PM, in the presence of the survey team, the Director of Nursing (DON) provided the incident/accident (I/A) report dated 5/07/24 and stated that all she had. The DON added that she knew what had happened, the resident was alert and able to explain that the bruises were obtained during blood drawn. The DON stated that she did not have an investigation. There were no employee statements from the prior three shifts included in the incident report provided. The I/A report included the CNA statement who worked and reported the bruises on 5/07/24 around 4:00 PM. There were no written statements obtained from the the day shift staff involved with Resident #6's care. Attached to the I/A Report was a form titled, Skin Tear and Bruise Investigation, dated 5/07/24 completed by the RN. Under the steps to follow, the following were documented under step #:5- Assess age of bruise/skin tear. Dried blood? Closed and healing wound? Color of bruising ? Swelling? the RN documented, Dark -purplish bruising on both forearms, mild swelling on right arm. #7 What does the resident say about how the I/A occurred? Said it happened when CNA#1 also assisted during blood work the previous day (5/06/24) CNA#2 who worked the 3:00 PM-11:00 PM shift, documented, I notice the bruise on both arms when I transfer the resident to bed and changed the clothing. I notified the nurse. The Interdisciplinary Notes attached to the I/A report indicated the following: Resident #6 was noted to have bilateral antecubital hematoma down to forearm in the area. Resident #6 had lab work drawn on 5/06/24. No bleeding noted, and the area will be monitored. Resident #6 is questioning frequent blood work, will review with physician and NP. Will monitor for worsening. Educate technician. Resident #6 is on Eliquis twice daily. Resident #6 states that their arm was held tight while the lab was being drawn. The line of the tourniquet could be seen on bilateral arms. On 5/28/24 at 12:52 PM, CNA#1 was interviewed again with another surveyor. She stated that she was already in the room assisted another resident when she heard the exchange between the lab technician and the resident. The resident did not want the lab to be drawn, she came and stood at the bedside and Resident #6 held her hands. The CNA denied that she held the resident's arm for the blood work. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 5/28/24 at 02:30 PM, the DON provided the investigation summary. According to the interview, Resident #6 told the DON both CNA#1 and the phlebotomist held their arms down to draw blood. A telephone statement obtained from the lab technician dated 5/24/24 indicated, Resident #6 did not like having the blood drawn. Resident got aggressive that day and wanted to hit me. Resident #6 slapped and since CNA#1 was there, I asked the CNA to help. On 5/29/24 at 8:44 AM, the surveyor interviewed the RN in charge of Resident #6's care. The RN stated that she was at the desk when she heard the screaming, she went to the room and the blood work was already in process, she remained in the room until the lab work was completed. She confirmed that the resident was not informed of the blood work for 5/06/24 nor made aware of the lab result of 5/03/24. On 5/29/24 at 9:15 AM, the surveyor interviewed the Assistant Physician Nurse(APN) in charge of Resident #6's care. The APN, stated that she was not made aware of the lab work being done for 5/03/24 and 5/06/24. The APN was made aware of the bruises on 5/08/24 and spoke with the nurse, who stated that the bruises were obtained during lab being drawn. On 5/29/24 at 9:24 AM, the surveyor interviewed the Licensed Social Worker (LSW) who stated that she spoke with the resident during the Quarterly meeting on 5/16/24 and the resident expressed some concerns with recent lab being drawn. The resident reported bruises on both arms obtained with recent lab work. When I observed the arms for bruises, it was already faded. On that same date and time, the LSW informed the surveyor that on 5/16/24 she discussed the issue with the DON. The LSW went on to state that the resident stated in the presence of the Power of Attorney (POA) that I am not happy about the recent lab work, I got blood work a few days ago (5/03/24 and few days later (5/06/24) someone showed again for blood work I said No I wanted the result from the previous blood work. The lab technician asked the CNA to hold my hand for the blood work, it was very uncomfortable and resistive. On 5/29/24 at 10:36 AM, the surveyor interviewed the physician regarding the lab work done on 5/03/24 and 5/06/24. The physician informed the surveyor that he was not aware of the lab work. He reviewed the lab work today 5/29/24. He further stated that his expectation was that he would be notified of any abnormal lab result. 31654 2. The surveyor reviewed a Reportable Event Record (RER) that had been submitted to the Department of Health (DOH) by the facility DON on 02/09/24 at 12:34 PM revealed: Today's date: 02/08/24 Date of Event: 02/08/24 Time of Event: 6:30 PM Was this a significant event? Yes. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Type of Incident: Staff- to- Resident Abuse. Narrative: Resident #85 stated private part was washed roughly by the nursing assistant who got the resident ready for bed on Saturday evening 02/03/24. Resident #85 stated heard Resident #42, speaking in a foreign language and stated the same thing and that's why he/she reported this issue today 02/08/24. Resident #42, upon interview [untimed] stated that during care a few days ago, a [color] male nursing assistant with curly hair entered the room, took the resident do the bathroom and put his mouth on [genital organ]. 2. Prior to the event, was a plan of care developed that addressed this issue: No. 3. What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, CNA suspended. Please describe investigative findings/conclusions: -Both residents were interviewed and total body assessment were completed immediately 02/08/24. -Staff identified and was send home immediately. -Family and physicians were notified. -Police Department was notified. Investigation on going. The undated Investigation Summary submitted by the facility revealed: Investigation: On 02/08/24, Resident #85 reported to the nurse on duty, that the resident did not like the way the male nursing assistant who provided care on Saturday evening and washed resident's private part. The nurse informed the DON who went to further interview Resident #85. Resident #85 stated that on 02/03/24 the aide was washing his/her private area kind of in a rough manner. Resident #85 stated that on 02/03/24, heard Resident #42 talking in a [foreign language] in the hallway about the same thing. When Resident #85 was asked why did not report the incident sooner, resident stated it had been on resident's mind to report it but he/she did not. DON and a [foreign language] speaking staff interviewed Resident #42. Resident #42 explained maybe two nights before, around midnight, a male went into resident's room, led him/her to the bathroom and while in the bathroom, the aide put his mouth on his/her [genital organ]. Resident #42 stated that he/she told his/her family member (FM). About the incident who told the resident to let it go and stop talking about it. The DON placed a call to the FM and asked why the FM did not report the incident. I did not know what to make of it, my [parent] is confused and has been upset about [spouse] being in the hospital and I thought that is what was bothering him/her, [parent] is very private and does not want anyone to care for him/her (continued on next page)

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F 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Note: The nursing home is disputing this citation.

The involved CNA#3 was interviewed and denied the accusation. CNA#3 stated he was assisting Resident #42 to the toilet when the FM arrived at the floor, the CNA left when FM entered the room.

Both residents were interviewed by the Police.

The roommate of Resident # 85 was present in the room during all interactions and denied seeing or hearing any incidents.

Both Residents had complete skin assessment and no injuries noted.

Summary/Conclusion:

-The Allegation was Unsubstantiated.

-According to the staff, Resident #42's FM visited right when CNA#3 was with Resident #42 and entered the room before the CNA left.

-CNA#3 stated he only assisted the resident at that time before his/her FM visited and that the FM met the CNA in the bathroom with the resident when he was sitting Resident #42 down on the toilet and left the resident in the care of the FM.

- All alert and oriented patients on the unit who were cared for by the employee were interviewed and did not report any concerns.

Interventions:

-Both Residents #42 and #85 were educated on reporting incidents immediately.

-FM was educated on reporting incidents regardless of the residents' cognition or description of the incident.

-Both residents were assessed, complete body assessment was done with no abnormalities noted.

-Both residents were referred for psychology consult for emotional support.

-Incident reported to the Ombudsman.

-The employee was an agency staff; he was suspended immediately pending the investigation and will not return.

On 5/23/24 at 10:30 AM, the surveyor reviewed the electronic Medical Record (eMR) for both residents to determine compliance with the investigation submitted by the DON.

Resident #85's AR revealed diagnoses which included, but were not limited to; type 2 diabetes, Parkinson's Disease and major depressive disorder.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	A review of the 22-page current CP with a target date of 7/19/24 and including resolved items, did not reveal a Focus related to the allegation of sexual abuse that occurred on 02/03/24 and was reported on 02/08/24. A review of the multi-disciplinary PN from 01/29/24 through 02/26/24 did not reveal a nurses note or physician documentation related to the allegation of sexual abuse that occurred on 02/03/24 and was reported on 02/08/24. A physical, psychosocial or any other type of assessment related to the allegation of sexual abuse was not located in the eMR or paper medical record. There was no assessment and complete body assessment completed and documented as per the facility documented interventions. There was no psychology consult for emotional support documented in the medical record and as per the facility documented interventions. The most recent Annual MDS of Resident #85 indicated a BIMS score of 14 out of 15 that showed resident was cognitively intact. On 5/28/24 at 8:20 AM, the surveyor conducted an interview with Resident #85 while the resident was in the room eating breakfast. The surveyor asked the resident about any concerns that occurred with any staff. Resident #85 stated, a CNA touched him/her in the private area inappropriately and stated the CNA did it when he was getting Resident #85 ready for bed. Furthermore, Resident #85 stated the same day a few hours later, the resident overheard Resident #42 stating the same CNA touched Resident #42 touched him/her inappropriately and Resident #85 reported it 1-2 days later. Resident #85 confirmed the police came and interviewed Resident #85. When asked about the roommate being present at the time, Resident #85 stated the curtain was drawn. On 5/28/24 at 8:53 AM, the surveyor requested, from the Licensed Nursing Home Administrator (LNHA) and the [NAME] President of Risk Management (VPoRM) the investigations related to Resident #42 and Resident #85's allegations of abuse and specifically requested the documents in their entirety, including any statements and any documents utilized to complete the investigation and completed because of the investigation. On 5/28/24 at 9:20 AM, the VPoRM provided the surveyor with, what he confirmed, was the completed facility investigation. The surveyor initially reviewed the documents which included one document titled Witness Statement from the accused CNA#3, and a type written undated document. The surveyor again requested all documents from the DON, in the presence of the VPoRM regarding statements and any investigative documents that were reviewed to determine the conclusion of the investigation. The DON pointed to her type-written summary and stated, those were the statements. On 5/28/24 at 9:35 AM the DON, in the presence of the survey team, stated that the two documents provided, one titled Witness Statement and the other untitled document were the only separate statements as part of the investigation. The surveyor asked why the typed statement was not dated and she stated, it was a mistake. The surveyor requested the information when the accused CNA#3 worked and requested the time punch logs. The surveyor asked the DON about any assessments that were completed as alleged and the DON stated, that usually when we do a regular body assessment, we put a note in the [eMR]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Excel Care at Dover		STREET ADDRESS, CITY, STATE, ZIP CODE 65 North Sussex Street Dover, NJ 07801	

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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 0610

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Note: The nursing home is disputing this citation.

At that time, the surveyor notified the DON that there were no documented assessments in the eMR and she did not provide any assessments for any other residents that may have been affected or the alleged victims. The DON stated, if it is not there, then I did not do it. The surveyor asked the DON when the accused CNA#3 provided a statement, and the DON stated he was asked to come in to only fill out a statement and she will look for additional documents related to the investigation.

A further review of the facility provided investigation revealed the following documents:

-A copy of a police officer's card (there were no police reports included in the investigation). The surveyor requested a copy of the police reports from the VPoRM as the facility confirmed they never requested the reports.

- The RER

- A handwritten Witness Statement Date of Incident: [Left Blank]; Time of Incident: [Left Blank]; Date and Shift of Witness Involvement: 7-3; Job Title: CNA#3; Please describe what happened in detail: The bed alarm went off for [Resident #42's room] so I went to check since [CNA #4] was with another resident. I took [him/her] to bathroom when [he/she] asked me when I arrived to [his/her] room. The FM came into the bathroom while I was sitting the resident down. I then left and the FM was going to help [Resident #42] afterwards. [Resident #42] then came a couple of hours later exclaiming that I did inappropriate things to [him/her]. I informed nurse and the family when they came back. Signed by CNA#3, Date Completed: 02/08/24.

- A type written document, undated and signed by [CNA #4] revealed: I was assigned to Resident #42 for the shift; while I was assisting another patient (also known as resident) next door, the other CNA came to me to tell me that Resident #42 needed help. I asked him to go help the resident as I was busy. When I came out of the other patient's room, I saw the FM of Resident #42 in the hallway and he/she asked me where Resident #42 was and I told FM they took him/her to the bathroom; the FM opened the bathroom door to check on the resident and I saw CNA#3 leaving the room. After a while, the FM left, Resident #42 was saying no good, no good, but when I asked [him/her] what happened [he/she] did not say anything. I helped the nurse take Resident #42 back to their room. The document was signed and undated.

There was no documented statement from Resident #42 or the roommate, Resident #85, the FM, nurse, or any other staff or residents who may have been a witness.

The Investigation Summary:

On 02/08/24, Resident #85 reported to the nurse on duty, that he/she did not like the way the male nursing assistant who provided care on Saturday evening and washed his/her private part. The nurse informed the DON who went to further interview Resident #85.

Resident #85 stated that on 02/03/24 CNA#3 approached him/her and asked if the resident was ready to be washed for bed. Resident #85 stated that CNA#3 washed him/her, felt was washing his/her private area kind of in a rough manner. No documented statements from the nurse on duty or the DON were included and no statements were obtained from any other staff or residents cared by CNA#3 .

(continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Resident #85 stated that on 02/03/24, heard Resident #42 talking in a [foreign language] in the hallway about the same thing. When Resident #85 was asked why did not report the incident sooner, resident stated it had been on resident's mind to report it but he/she did not. DON and a [foreign language] speaking staff interviewed Resident #42. There was no statement included in the investigation from the DON or foreign speaking staff. Resident #42 explained maybe two nights before, around midnight, a male went into resident's room, a male with a lot of hair, medium built-in stature, led the resident to the bathroom and while in the bathroom, the aide put his mouth on resident's [genital organ]. There were no additional details included in the description as to what was provided to the DOH, and there were no documented statements from Resident #42. When the DON asked Resident #42 what the resident did about it and why the resident did not report it. Resident #42 stated he/she chased CNA#3 out of the bathroom and told the FM who then told him/her to let it go and stop talking about it. There was no additional information added from the DOH submission and no documented statements included. The DON placed a call to the FM. The FM explained that visited Resident #42 multiple times that day and spoke to Resident #42 who then told the FM what happened. The DON placed a call to the FM and asked why the FM did not report the incident. I did not know what to make of it, my [parent] is confused and has been upset about [spouse] being in the hospital and I thought that is what was bothering him/her, [parent] is very private and does not want anyone to care for him/her. DON educated FM to immediately report any incidents. The involved CNA#3 was interviewed and denied the accusation. CNA#3 stated he was assisting Resident #42 to the toilet when the FM arrived at the floor, the CNA left when FM entered the room. The documented Witness Statement from the CNA differs from this account and from CNA #4's documented statement and was not further investigated. CNA #4, the assigned CNA stated that the FM spent some time with Resident #42, then left with no issues. CNA #4 stated that sometime later after the FM left, she saw Resident #42 in the hallway upset saying no good but was redirected back to resident's room. A Nurse on duty stated that the FM visited multiple times during the shift. She stated that nothing was reported to her at that time and the FM left. There was no statement included from the nurse in the investigation. Both residents were interviewed by the police department: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Resident #85 reported to the police, in the presence of the DON, that felt as if washed roughly. Resident #85 told the officer that reported the incident because Resident #42 said the same thing in a foreign language. Resident #42 repeated the same thing he told the DON to the officer. The roommate of Resident # 85 was present in the room during all interactions and denied seeing or hearing any incidents. Both Residents had complete skin assessment and no injuries noted. Summary/Conclusion: (Differed from the original that indicated the allegations were unsubstantiated.) The facility could not conclude whether the nursing assistant did put his mouth on Resident #42's genital, or whether CNA#3 roughly washed or fondled Resident #85. According to the staff, the FM visited right when the nursing assistant was with the resident and entered the room before the staff left. CNA#3 stated that he only assisted the patient at that time before the FM visited and that the FM met him/her right when he/she was sitting him/her down on the toilet; and that he left the patient in the care of the FM. The resident's FM stated that Resident #42 did not tell him/her about the incident when visiting and met him/her in the bathroom, until the FM came back later about 8-8:30 PM. All alert and oriented residents on the unit who were care for by the employee were interviewed and did not report any concern with regards to him rendering care. On 5/28/24 at 10:04 AM, the surveyor asked the DON, who was looking through documents in her office, about any additional investigation documents including statements and the DON stated she will continue to look and asked Human Resources for the punch in and out logs for CNA#3. The DON stated, if she did not have anything else she would let the surveyor know. On 5/28/24 at 10:21 AM, the DON stated she cannot locate any other documents. On 5/28/24 at 10:30 AM, the LNHA provided the dates CNA#3 worked at the facility which included the following dates and punch in and out times: 1. 01/28/24- 7:26 AM-3:09 PM 2. 01/28/24- 3:09 PM-10:55 PM 3. 02/03/24- 3:10 PM-10:51 PM 4. 02/04/24- 7:13 AM-3:00 PM (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	5. 02/04/24-3:00 PM -10 (area x) 6. 02/06/24-8:38 AM-3:11 PM 7. 02/06/24- 3:13 PM-10:41 PM 8. 02/08/24- 8:42 AM-3:02 PM On 5/28/24 at 11:10 AM, the surveyor interviewed the Director of Social Services (DSS) who stated she had been at the facility for three months. She stated she was the Grievance Officer. The surveyor asked what the protocol for abuse was. She stated if she received an allegation of abuse, she would inform the LNHA and DON. She stated she interviewed residents and family and would document in the grievance book. On that same date and time, the surveyor asked the DSS if she had a grievance for abuse from Resident #85 and #42 and she stated, not that she was aware of. The surveyor asked what constituted abuse and she stated if a resident felt they were touched inappropriately, or any signs of bruises that she would interview the resident and anyone involved. The surveyor asked if there was a process for the investigation and she stated she would look for it. On 5/28/24 at 11:20 AM (Resident #85) and 01:01 PM (Resident # 42), the VPoRM provided copies of two police reports which he obtained from the police department. The repots both revealed the DON reported the allegations on 02/09/24 at 9:07 AM. The Investigation Report for Resident #42 detailed a narrative and the officer interviewed the resident (DON not indicated as present for this interview as documented in the summary) and the report documented . the CNA escorted the resident to the bathroom, began to fondle his/her genitals and performed [inappropriate sexual action] on Resident #85 .The narrative for Resident #42 documented . that after the resident heard the account being yelled by Resident #85, he/she informed the staff the he/she was sexually assaulted on 02/03/24 by the same CNA (DON not indicated as present for this interview as documented in the summary) . Resident #42 was escorted to the bathroom by CNA#3, washed genitals, and fondled his/her genitals and then told CNA#3 to stop . On 5/28/24 11:32 AM, the survey team met with the LNHA, DON, [NAME] President of Clinical Services (VPoCS) and VPoRM. The surveyor asked if there was anything that provided guidance to staff regarding what is supposed to be completed in the event of an allegation of abuse. At that time, when asked about the investigation related to Resident #85 and #42, the DON confirmed there were no other individual statements taken from any other residents and the LNHA confirmed he did not review the investigation. On 5/28/24 at 11:35 AM the surveyor, asked the DON where the supporting documents regarding any interviews of any other residents and any other supporting documentation regarding the investigations. The DON stated I included what I had, everyone that was able to tell me, but only the alert and oriented residents could give me a statement and I did not go to the non-alert residents that could not speak. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	At that same time, the LNHA stated we go to the oriented person first, and asked staff if they saw something. The LNHA did not explain why there were no documented interviews or assessments completed with other residents and why non-alert residents were not assessed. The DON then stated, she spoke to residents as soon as she found out and it was not documented. On 5/28/24 at 11:50 AM, in the presence of the survey team, the surveyor asked the LNHA about who was responsible to ensure an investigation was completed and he confirmed that he was responsible for the overall process and ensuring the statements were completed. The DON stated, it was just the two CNA's, the one involved and the other one. On 5/28/24 at 12:27 PM, the surveyor interviewed the FM of Resident #42, in the presence of the survey team, regarding the incident. The FM stated the resident told him/her that the nurse did something to me, he put is mouth on [private area]. The FM also stated that other staff, including a nurse, informed the FM what happened with Resident #42 and CNA#3. The FM also stated that Resident #42 informed his/her spouse about what happened. When the surveyor asked the FM if he/she was ever asked to document a statement, the FM responded, never. The FM also remembered speaking with the CNA who told the FM that Resident #42 stated to him, that he did not touched Resident #42. On 5/28/24 at 01:01 PM, the VPoRM provided a second abuse policy stated it included the procedures that should have been followed for the investigation. At that time, the surveyor requested the assignments sheets from the VPoRM for CNA#3 for the days he worked when the allegation occurred. The VPoRM stated, that would need to be researched and the VPoRM confirmed the assignment sheets were not part of the investigation. The policy titled, Abuse Investigation and Reporting Policy, dated 05/01/24 which revealed: Intent: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Procedure: Role of the Administrator 1. If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. 2. The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation. 3. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Role of the Investigator: The individual conducting the investigation will, as a minimum. -Review the completed documentation forms. -Review the resident's medical record to determine events leading up to the incident. - Interview the person(s) reporting the incident. - Interview the resident. -Interview other residents to who the accused employee provides care or services. - Interview the residents' s roommate, family members, and visitors. The following guidelines will be used when conducting interviews: . -Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it. On 5/28/24 at 02:15 PM, the LNHA, upon inquiry by surveyor provided a copy of an invoice from the Staffing Agency that CNA#3 was sent home early and does not indicate the exact time on 02/08/24. On 5/29/24 at 12:52 PM, the above concerns were shared with the LNHA, DON, VPoCS and VPoRM and there was no additional information provided during the exit held conference on 05/31/24 at 11:56 AM. 48422 2. On 5/24/24 at 10:29 AM, the surveyor interviewed the Occupational Therapist (OT). The OT stated [he/she] recalled an incident that happen [TRUNCATED]

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38079 Complaint NJ #158377 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) document medications and treatments according to physician's orders for one (1) of 32 residents (Resident #18) reviewed for medication and treatment administration, and b.) consistently document catheter urinary output according to the physician's orders for one (1) of three (3) residents reviewed for urinary catheters (Resident #125) according to standards of clinical practice and facility policy. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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. 1.) On 5/21/24 at 9:09 AM, Surveyor #1 observed Resident #18 lying in bed on an air mattress, wearing glasses, and the call bell in reach. Resident #18 was alert and oriented and stated he/she was in the hospital recently and had been at the facility a while. Resident #18 was unable to tell the surveyor of all the previous hospitalization s. Surveyor #1 reviewed a previous readmission record for Resident #18. Resident #18's Admission Record (AR, or face sheet, an admission summary) reflected a readmission from the hospital with diagnoses included but were not limited to; Multiple Sclerosis (MS, a disease in which the immune system eats away at the protective covering of nerves), contractures, multiple wounds, skin rash neuromuscular dysfunction of the bladder, elevated blood pressure, and glaucoma (a group of eye conditions that can cause blindness). A review of the facility provided, Physician Orders report from the previous electronic medical record system, included the following: Created 8/25-8/26/2022, 26 orders including medications (meds), treatments, supplements, and tasks. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the electronic Medication Administration Record (eMAR) and the electronicTreatment Administration Record (eTAR) both dated September 2022, revealed the following documentation of X Not Addressed on 9/04/2022: Latanoprost eye drop scheduled at 21:00 (9:00 PM) Olopatadine eye drop scheduled at 18:00 (6:00 PM) Polyethylene powder (medication mixed with liquid for constipation) scheduled at 21:00 Tiazanidine (medication for MS) scheduled at 17:00 (5:00 PM) Tecfidera (medication for MS) scheduled at 18:00 Metoprolol (medication for high blood pressure) scheduled at 17:00 Resource Oral Liquid supplement scheduled at 19:00 (7:00 PM) Nystatin Cream wound treatment for the perineum scheduled at 17:00 ProSource liquid supplement scheduled for 16:00 (4:00 PM) Nystatin Cream wound treatment left upper thigh scheduled at 17:00 Nystatin Cream wound treatment groin folds scheduled at 17:00 Urinary catheter care scheduled for 14:00 (2:00 PM) and 22:00 (10:00 PM) Irrigate urinary catheter scheduled for 13:00 (1:00 PM) and 21:00 (9:00 PM) Out of Bed scheduled for 13:00 Turn and Reposition every 2 hours scheduled for 13:00 and 21:00 Wound treatment genital area scheduled for 17:00 Wound treatment both feet and toes opening scheduled for 9:00 AM and 17:00 Wound treatment left ankle scheduled for 9:00 AM and 17:00 Wound treatment a second genital area scheduled for 9:00 AM and 17:00 Wound treatment of the ischium (hip area) scheduled for 9:00 AM and 17:00 Wound treatment left lateral foot middle scheduled for 9:00 AM and 17:00 Wound treatment left lateral foot second area scheduled for 9:00 AM and 17:00 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident-centered on-going care plan (CP) included but was not limited to; dated 6/02/21: at risk for pain, pressure ulcers, contractures, MS, and sacral wound with interventions including assist with positioning and administer pain medications as ordered. At risk for skin breakdown, limited mobility, incontinent, MS, readmission from hospital with wounds with interventions assist with turning/repositioning, administer supplements, offload heels, wound treatments as ordered. At risk for UTI [Urinary Tract Infection] history of recurrent UTI, use of suprapubic urinary catheter with interventions irrigate catheter per orders, observe for signs and symptoms of infection, change catheter as ordered, catheter care as ordered, and empty urinary drainage bag every shift. A review of the Progress Notes (PN) ranging from 9/02/2022 through 9/07/2022, contained no documentation as to why the meds, treatments, and tasks were marked as not addressed. The PN contained no documentation to the physician or family regarding the meds, treatments, and tasks marked as not addressed. On 5/29/24 at 9:41 AM, during an interview with the surveyor, the Director of Nursing (DON) was questioned if a eMAR or eTAR documented an x, what would that indicate. The DON stated it would mean not given and that there are codes on the bottom [of the eMAR/eTAR] to indicate the documentation. She further explained that if a resident did not receive a med or treatment, the expectation would be to see a PN, call the pharmacy, and call the physician. The DON stated, There should always be a code why med was not given and a PN. On 5/29/24 at 12:03 PM, the survey team met with the facility administration. Surveyor #1 presented the concerns regarding Resident #18. On 5/30/24 at 10:25 AM, the facility [NAME] President of Clinical Services (VPoCS) stated the facility reached out to the nurses working 9/04/22, but it was too long ago, and the nurses could not provide any information. She further stated that if the documentation was noted as not addressed, the staff should have reached out to the physician, but we have nothing else. At that time, the DON acknowledged that the facility was responsible to provide the ordered meds and treatments, but there was no more information the facility could provide. The DON further stated that if a resident was not provided physician ordered meds or treatments, that the resident condition could worsen. 38327 2.) Surveyor#2 (S#2) reviewed the medical record for Resident #125. Resident #125's AR reflected that the resident was admitted to the facility with diagnoses that included but were not limited to urinary tract infection, site not specified, benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty) without lower urinary tract symptoms, and unspecified dementia (a group of thinking and social symptoms that interferes with daily functioning). The most recent comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, dated 3/19/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had an intact cognition. The cMDS also showed that the resident had an indwelling catheter. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Order Summary Report (OSR) for May 2024 reflected a physician's order (PO) dated 4/23/24 for Urinary Catheter Care every shift. The order was plotted in the May 2024 eTAR for day, evening, and night shifts to include the output. The May 2024 eTAR revealed the urinary catheter output was not documented for the following days and shifts: May 2024: 5/02/24 evening and night shifts 5/07/24 evening shift 5/14/24 to 5/16/24 evening shift 5/19/24 evening shift 5/21/24 evening shift 5/23/24 evening shift On 5/24/24 at 10:13 AM, the survey team met with the VPoCS, Licensed Nursing Home Administrator (LNHA), and the DON. S#2 notified the facility management of the above findings and concerns regarding omitted documentation of urine output in the May 2024 eTAR and did not follow the PO. On that same date and time, both the VPoCS and DON stated that they (nurses) should put an output or zero if no output in the eTAR and follow the PO. On 5/28/24 at 8:33 AM, the surveyor observed Resident #125 in their room seated in a wheelchair during breakfast. According to the resident, the Foley catheter was due to bladder and prostate cancer. On 5/29/24 at 12:02 PM, the survey team met with the LNHA, DON, VPoCS, and VP of Risk Management (VPoRM). The surveyor discussed the above concerns. A review of the facility's Infection Control-Indwelling Urinary Catheter Use dated 4/01/24 that was provided by the Infection Preventionist Nurse, included that it is the policy of the facility to ensure the appropriate use of indwelling urinary catheters in accordance with state and federal regulations, and national guidelines. Procedure: #9. Documentation to include urine output and monitoring for signs and symptoms of infection. On 5/30/24 at 11:59 AM, the survey team met with the LNHA, DON, VPoRM, and VPoCS. The DON stated that the nurse failed to put the urine output in the eTAR according to the PO. She further stated that the nurse should follow the order to document the output in the eTAR. NJAC 8:39-27.1(a), 33.2 (c) 5

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NAME OF PROVIDER OR SUPPLIER Excel Care at Dover		STREET ADDRESS, CITY, STATE, ZIP CODE 65 North Sussex Street Dover, NJ 07801	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Complaint # NJ162913 Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure there was no delay in addressing laboratory (lab) values in a timely manner for two (2) of two (2) residents (Resident #6 and #109), b.) notify the physician of the the change in condition generated by a [health alert system] for three (3) of three (3) residents (Residents #6, #109, and #330), c.) monitor the skin, specifically the arm of Resident #109, who had a known behavior of scratching, and d.) provide wound care in accordance with professional standards of practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes 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. 1. On 5/21/24 at 10:04 AM, the surveyor observed Resident #109 seated in the room. The surveyor observed some bruising to the right eyebrow and a non adherent dressing to left upper arm. The resident was unable to participate in an interview. On 5/22/24 at 10:43 AM, the surveyor observed the resident sitting in the room. The electronic Medical Record (eMR) was then reviewed which revealed that the resident had sustained multiple falls at the facility and that Resident #109 was a high fall risk. On 5/23/24 at 8:40 AM, the surveyor observed the resident in bed, and at 9:44 AM, the surveyor observed the resident sitting in a wheelchair in the room and was eating breakfast. The surveyor again reviewed Resident #109's eMR which revealed: The Admission Record (AR, or face sheet, an admission summary) reflected that Resident #109 was admitted to the facility with diagnoses which included, but was not limited to; other abnormality of gait and mobility, unspecified Dementia and mood disturbances. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Annual and the Significant Change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, respectively dated 02/20/24 and 02/29/24, indicated that Resident #109 scored 01/15 on the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. Review of a Nursing Progress Note (PN) dated 5/20/24 at 01:22 PM, indicated that Resident #109 had a skin tear to right arm with skin breakage with clear drainage and small, reported from scratching. Injury cleaned with saline and bordered gauze dressing applied for protection. On 5/22/24 at 23:07 the nurse documented: Skin issue # 001 Needs Review. Issue type: Bruising . Location right upper arm. #002 Needs review Issue type Laceration. Right upper arm. #003 Needs Review Issue Type: Laceration. Location: Right anterior elbow. Skin is fragile: redness noted to bilateral hands., and full thickness wound to right upper arm. Another entry dated 5/22/24 time 11:39 PM indicated the following: Foul odor and slough noted to wound right upper arm, endorse to night nurse to follow up with wound care nurse. Further review of the medical record revealed there was no documentation regarding the wound to indicate any follow up was completed. A review of the Physician PN did not reflect evidence that the attending Physician was aware of the resident's right upper arm wound having a foul smell. There was no documented evidence that the skin issue was addressed with the Physician. The facility did not alert the Physician of the change in condition regarding the redness on both hands and the full thickness wound to the right upper arm. The area was not measured. The PN of 5/23/24 timed 3:13 PM revealed: [health alert system] (remote patient monitoring device placed within a detectable range of each patient that alerted the staff of any change in condition). Protocol Upon receiving the alert, the resident had to be assessed, vital signs had to be monitored every shift for 3 days, lab work, Comprehensive metabolic profile and and Complete Blood Count (CBC) had to be ordered. Staff were to monitor the lab result and alerted the Physician or the Assistant Physician Nurse (APN) of the result. Resident #109 had another [health alert system] alert on 5/23/24 at 21:50 [9:50 PM]. Laboratory blood drawn on 5/24/24 at 5:53 AM revealed a blood sugar of 61. Normal Range 65-99 mg/dl. The result was forwarded at 3:56 PM. The surveyor reviewed the result on the eMR with the Infection Preventionist/Registered Nurse (IP/RN). Both the surveyor and the IP/RN noted that the result was marked as Not reviewed on 5/29/24. There was no documented evidence that the Physician was notified of the low blood sugar. On 5/29/24 at 10:36 AM, during an interview with the Physician, he revealed that he was not informed of the low blood sugar or any change in condition regarding Resident #109. He acknowledged that he reviewed the lab result today 5/29/24 (5 days later). 2. The surveyor reviewed the medical records of Resident #6 as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #6 was admitted to the facility with diagnoses which included, but were not limited to chronic kidney disease, difficulty in walking, need for assistance with personal care. The Quarterly MDS dated [DATE] revealed that Resident #6 had a BIMS score 11 out of 15 indicative of moderate cognitive impairment. On 5/02/24 Resident #6 had a [health alert system] alert. The protocol was for a physical assessment to be done, vital signs and lab work to be completed and report any abnormal lab work to the Physician. Resident #6's blood work was collected on 5/03/24 at 11:47 AM. The result was available the same day at 9:39 PM. A potassium (electrolyte that helps with nerve function, muscle movement heartbeat regulation) level of 2.8 was detected. Normal range 3.4 -5.3 mMOL/Liter (millimoles per liter). The facility did not checked the result or alert the Physician of the [health alert system] alert. The result status was checked and revealed that the blood work had not been reviewed as of 5/29/24 (26 days later). On 5/29/24 at 9:15 AM, the surveyor interviewed the APN regarding the [health alert system] alert of 5/02/24 and the lab result of 5/03/24 with the low potassium level for Resident #6. The APN informed the surveyor that she was not made aware that Resident #6 had blood drawn on 5/03/24. Regarding the potassium level of 2.8, she informed the surveyor that she would have addressed it if she was was made aware. On 5/29/24 at 10:36 AM, the surveyor interviewed the Physician in charge of Resident #6's care. The Physician stated that the [health alert system] alert was a good system that can alert of any change in condition and avoid hospitalization . However, the staff needs to communicate with the physician. The Physician stated that he was not made aware of the [health alert system] alert and the abnormal lab result. The physician stated that his expectations were the facility will either communicate with the physician or the APN any concerns regarding the resident. 3. On 5/23/24 the surveyor reviewed the closed medical record of Resident #330. Resident # 330 was admitted to the facility with diagnoses which included but were not limited to; muscle wasting, dysphagia (problem with swallowing) and difficulty in walking. The New Jersey Universal Transfer Form dated 02/20/23 reflected that Resident # 330 was admitted with one stage 2 pressure ulcer to the coccyx area measuring 1 centimeter (cm) x 1 cm x 0.2 cm. The admission record 02/14/23 contained an order to provide wound care every shift. Cover with layer of Xeroform, 2 x 2 gauze. Call wound care nurse for any changes in wound characteristics. Wound location: left lower Sacrum/ Coccyx. Wound type: Pressure Ulcer. Stage: Stage 3 or full thickness Cleanse with wound cleanser, apply venelex Change : Every shift. The physician order sheet dated 02/14/23, had an order for Resident #330 to be turned or repositioned every or within two hours of last turned. The surveyor reviewed the PN and noted that staff documented that the resident was being turned and repositioned every 2 hours as ordered and that wound care was being done. The Braden Scale assessment dated [DATE] timed 01:29 AM, revealed that the resident was a high pressure ulcer risk and was constantly moist by perspiration or urine. Resident # 330 received a score of 10 indicative of high risk for pressure ulcer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/02/23 the Health Status Note dated 3/02/23 indicated that Resident #330 was seen by the Wound nurse and the wound treatment was changed from zinc oxide and replaced with Santyl a debrided agent. The electronic Treatment Administration Record (eTAR) was not signed to indicate that the wound care was being done from 3/03/23 to 3/16/23. A skin check was ordered for every evening shift on Wednesday with a start date of 3/15/23. The skin checked was not signed as being done on 3/15/23. The eTAR revealed an order for Santyl external Ointment to apply to inner buttock every shift for pressure ulcer with a start date of 3/16/23. The eTAR was not initialed on 3/16/23, 3/17/23, 3/18/23, 3/21/23 and 3/23/23. The eTAR was left blank. There was no rationale to indicate why the wound care was not documented as completed on those five days. On 3/16/23 timed 23:54 (11:54 PM), a new skin issue was identified. The Physician entered a late entry dated 3/20/23 timed 14:31 (02:31 PM), Resident was seen for Wound Consultation follow up for wound management of open wounds of bilateral gluteal region and erythematous rash with denudements was to sacrum and bilateral gluteal region: -Wound (+) full-thickness of the left gluteal region, 0.6 centimeter (cm) x 3.0 cm.(merged site). Wound base with 50% yellow slough tissue and 50% granular tissue. -Wound (+) full-thickness of the right gluteus/ gluteal region gluteal region 0.5 cm x 1.3 cm. wound base 100% yellow slough tissue. -[plus sign] erythematous rash noted to the sacrum and bilateral gluteal region. denudes site of the left gluteal region measuring 1.5 x 1.0 cm. scant amount of drainage. Plan discussed with primary Physician. If applicable, pressure Ulcer Care, Application of ointment. A PN dated 3/24/23 timed 20:24 [8:24 PM], documented that the Resident Representative (RR) was upset over the worsening of the wound due to incontinence care not being provided in a timely manner. According to the documentation the wound care was not done as ordered. (The eTAR indicated that wound care was not completed on 3/16/23, 3/17/23, 3/18/23, 3/21 and 3/23/23.) On 3/24/23 timed 20:24 the Licensed Practical Nurse (LPN) documented the responsible party (RP) came in very upset c/o [complain of] resident bottom getting worse within a two days period, saying Resident #330 not being changed in a timely manner. Resident sacral wound dressing was changed at 18:00 (6:00 PM). The morning nurse said she got busy and could not do the dressing. An entry dated 3/25/23 timed 20:38 PM (8:38 PM), revealed that the Unit Nurse from the agency arrived to the floor at 7:45 PM and indicated that the RP was upset regarding the care. The nurse went to the 1st floor and observed two Certified Nursing Assistant (CNA) performing wound care to Resident #330's sacral wound. The Unit nurse was not on the floor at that time. The RP went to the Police Department and filed a complaint regarding the care. The RP took the resident home the same day at 8:57 PM. The facility administration was interviewed and did not provide any documentation regarding the above documented concerns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the Certified Nursing Assistant Job Description under specified duties revealed the following Assists the resident in maintaining and improving function, encouraging independence whenever responsible for the Activities of Daily Living, and overall hygiene of the resident: baths, shampoos, shaves, nail care mouth care, foot care and peri-care per facility policy. The job description did not indicate that CNA would perform wound care. A review of the Registered Nurse (RN) Job description indicated the following: As member of the Interdisciplinary team, the RN assumes responsibility and accountability for nursing services delivered to assigned residents of a designated unit for one shift. The RN provides direct care, administers treatments and medication, organize and distribute daily assignments to direct care staff consistent with staff competency and each individual resident's comprehensive resident assessment and plan of care. Supervises direct care staff and makes decisions about resident care needs during shifts concerning scope of clinical competence, consistent with facility policies and procedures. Ensures that Flow of Care is followed. The Director of Nursing (DON) job description indicated that the DON assumes full time administrative and clinical authority for the delivery of nursing services in the facility. Manages employees in the provision of care and services according to professional standards of nursing practice, consistent with facility philosophy of care and state and federal laws and regulations. Develops and implements policies and procedures consistent with current law. In collaboration with the Nursing Home Administrator, allocates department resources in an efficient and economic manner to enable each resident to attain or maintain the highest practicable physical, mental and psychosocial well-being . Makes daily rounds on unit to supervise, observe, examine, interview residents, to evaluate staffing needs, to monitor regulatory compliance, to achieve the care environment and to evaluate staff interactions and clinical skills competency. Review 24 hours reports from every unit daily to ensure timely, effective responses to significant changes in condition, transfers, discharges, use of physical or chemical restraints, unexplained injuries, potential abuse or neglect, medication errors, loss of resident property, any evidence of resident or family dissatisfaction. The DON could not comment on the documentation regarding Resident #330 as she was not employed at the facility when the incident occurred. On 5/30/31 at 01:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), [NAME] President of Clinical Services, and [NAME] President of Risk Management. The administrative staff did not provide any rationale for not informing the Physician of the change in condition for both residents. The DON acknowledged that the nurse should have notified the Physician regarding the laboratory work result. NJAC 8:39-27.1(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 38079 Complaint #s NJ157563, NJ158377, NJ159018, NJ162913, NJ169759, and NJ173245 Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure residents' were provided with care to achieve their highest practical wellbeing by failing to a.) provide adequate staff to ensure effective supervision and documentation for residents with multiple falls (Resident #89 and #109) for two (2) of four (4) residents reviewed for falls, and b.) maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Refer to F689H 1.) On 5/21/24 at 9:53 AM, Surveyor #1 (S#1) observed Resident #89 in the unit day room in a wheelchair (w/c) eating breakfast. A review of the electronic medical record (eMR) revealed that Resident #89 had: -falls: 02/09/24 and on 3/09/24 (fall with injury). -Resident #89 was documented to have a Brief Interview for Mental Status (BIMS) score of 03 out of 15 which indicated severely impaired cognition. Surveyor #1 reviewed the Incident/Accident (I/A) reports provided by the facility. The reports included but were not limited to the following: Dated 02/09/24, unwitnessed fall with no injury. The investigation did not include all pertinent staff statements, left blank areas that should have been filled out, fall inspection report done asked for footwear wearing of the resident at the time of fall and was left blank. Interventions added: Head to toe assessment. The report did not include a summary or conclusion and was not signed by the Licensed Nursing Home Administrator (LNHA) or Director of Nursing (DON). The facility did not identify the hazards and risks why the resident fell in order to implement interventions to reduce hazards and risk and modify the interventions when necessary when the resident was cognitively impaired. Dated 3/09/24, unwitnessed fall with no injury. Interventions added was left blank. Immediate interventions: Head to toe assessment, call bell within reach, patient educated to call for help. fall inspection report done. List of immediate interventions: head to toe assessment call bell within reach, patient educated to call for help. The report failed to identify the staff who found the resident on the floor. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	On 5/24/24 at 10:13 AM, in the presence of the survey team, the DON stated that the Certified Nursing Aide (CNA) who wrote the statement on 3/09/24 incident was late and nurse who was administering medications was supposed to take of care of Resident #89. Surveyor #1 then asked the facility management, how the only nurse on that unit, at that time be assigned also perform resident care from 7 AM to 9 AM, and why there was no CNA assigned to the resident instead. The DON stated that the two other CNAs were aware that they would take care of the resident even though they were not assigned. The surveyor also asked who were the two other CNAs and why there were no statements from them. The DON was unable to state the names of the two other CNAs and stated that she had the documentation. The DON was unable to provide the documentation from the two CNAs for 3/09/24 incident. On that same date and time, Surveyor #1 then asked the DON if the fall incidents on 02/09/24 and 3/09/24 were complete investigations. The DON stated, I did not write all the information and I should have went back and wrote in details. On 5/29/24 at 10:15 AM, Surveyor #1 interviewed the [NAME] President of Risk Management (VPoRM) who provided a typewritten Investigation Summary and Conclusion dated 5/24/24 for the two falls: 02/09/24 and 3/09/24. The VPoRM stated in the presence of the survey team that the Investigation Summary and Conclusion were completed after surveyor's inquiry. He stated the team decided to meet on 5/24/24 after surveyor's inquiry, to re-evaluate the two fall incidents of the resident in order to know the root cause and analysis, identify appropriate interventions to prevent further fall because as the surveyor identified and questioned the fall intervention to remind the resident to call for help was not appropriate due to resident's cognitive impairment. He further stated that the facility team acknowledged the surveyor's concern as well as the concern that the investigation had no statements and conclusion and summary for one fall incident. 2.) On 5/21/24 at 10:04 AM, Surveyor #2 observed Resident #109 sitting in their room. The surveyor observed a bruise on the right eyebrow. The resident was unable to be interviewed. On 5/22/24 at 10:43 AM, Surveyor #2 observed Resident #109 sitting in their room. On 5/23/24 at 8:40 AM, Surveyor #2 observed Resident #109 in bed resting. On 5/23/24 at 9:44 AM, Surveyor #2 observed Resident #109 in their room sitting in a w/c eating breakfast. A review of the eMR revealed that Resident #109 had multiple falls as follows: 12/26/23, 02/02/24, 02/20/24 fall with injury, 3/07/24, 4/06/24, 4/13/24, 5/19/24, and 5/25/24 fall with injury. Resident #109 was documented to have a BIMS of 01 out of 15 which indicated severely impaired cognition. A review of the resident-centered on-going care plan included but was not limited to; interventions of educate the resident to ask for assistance, keep resident in supervised area as much as she will allow, ensure appropriate footwear when ambulating, review past falls and attempt to determine the cause, and supervision. (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Note: The nursing home is disputing this citation.

On 5/28/24 at 11:08 AM, during an interview with Surveyor #2, the Licensed Practical Nurse (LPN) revealed that the resident was identified for frequent falls. The LPN stated that the staff needed to monitor and keep Resident #109 close to the nursing station, furniture was removed from the room, and to provide frequent toileting.

On 5/29/24 at 11:21 AM, Surveyor #2 called the family member (FM) regarding the resident and the falls. The FM stated that the resident was sent to the hospital for repair of resident's shoulder. The shoulder was pretty messed up. The FM further stated that the resident was sent to the operating room, started bleeding, and passed away that morning.

3.) On 5/31/24 at 8:26 AM, S#1 asked LNHA to describe the Facility Assessment (FA) 3.2 and what it meant as stipulated in the FA the following: Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time. Based on resident census and acuities, staffing is assigned to ensure there is sufficient staff to meet the needs of the residents at any time. Position Nurse aides, total number needed or average or range 39, licensed nurses providing direct care total number needed or average or range 19. The LNHA responded that it meant that any given time, the facility was required to have total or average range of 39 CNA and 19 nurses.

On that same date and time, the LNHA stated that he was aware of the staffing requirements and the New Jersey (NJ) mandated law. He further stated that he was aware that there were times that the facility was not meeting the requirements and the mandated law.

4.) Review of the NJ Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing as follows:

For the 2 weeks of staffing prior to survey from 05/05/2024 to 05/18/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows:

-05/05/24 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs.

-05/06/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs.

-05/07/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs.

-05/08/24 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs.

-05/10/24 had 16 CNAs for 136 residents on the day shift, required at least 17 CNAs.

-05/12/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs.

-05/13/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs.

-05/14/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs.

-05/15/24 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs.

-05/16/24 had 16 CNAs for 143 residents on the day shift, required at least 18 CNAs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	-05/18/24 had 17 CNAs for 146 residents on the day shift, required at least 18 CNAs. NJAC 8:39-4.1(a), 25.2(b), 27.1(a)