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	03/06/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2800328 Based on interviews, record review, and review of pertinent documents, it was determined that the facility failed to ensure staff did not neglect to carry out a physician's order to send a resident (Resident #1) immediately to the hospital, who had low blood pressure and a change in condition. The resident was sent later that day to the hospital by the physician and the resident expired at the hospital the same day. This deficient practice was identified for 1 of 3 residents reviewed for neglect (Resident #1). On [DATE] at 9:00 AM, the Assistant Director of Nursing (ADON #1) informed the surveyor that on [DATE], Resident #1 had a change in condition and the resident's Medical Doctor (MD #1) ordered the resident to be transferred to the hospital for evaluation and ADON #2 did not carry out the order. ADON #1 stated that later that day, MD #1 was at the facility conducting rounds, when she was alerted Resident #1 was still in the facility and she was upset and immediately sent the resident to the hospital. ADON #1 stated Resident #1 later expired that day in the hospital. ADON #1 stated that ADON #2 resigned from the facility on [DATE], for unrelated reasons. During an interview on [DATE], MD #1 stated that on [DATE], she ordered Resident #1 be sent to the hospital via 911 emergency services for low blood pressure. MD #1 continued that she had arrived at the facility on [DATE] at 10:00 AM, for scheduled rounds of her residents, and the Licensed Practical Nurse (LPN #2) informed her at 10:10 AM, that Resident #1 was still in the facility and 911 was not called. MD #1 stated that she spoke to ADON #2, who she had given the orders to, and ADON #2 told MD #1 that they were waiting on laboratory (lab) results prior to calling 911. MD #1 stated that she informed ADON #2 that Resident #1 needed to be immediately sent to the emergency room (ER), and that waiting on labs to be drawn was not appropriate for the resident's condition. The facility's failure to implement their abuse and neglect policy to ensure all residents were protected from neglect when staff neglected a physician's order to send Resident #1 immediately to the ER for evaluation, placed Resident #1 as well as all residents at risk for neglect. This posed the likelihood for serious harm, impairment, or death which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on [DATE] at 9:20 AM, when MD #1 ordered Resident #1 to be sent to the ER and the order was not immediately carried out. The facility's Administration was notified of the IJ situation on [DATE] at 2:30 PM. The facility submitted an acceptable Removal Plan (RP) on [DATE] at 10:38 AM. The survey team verified the implementation of the RP during the continuation of the on-site survey on [DATE], and determined the immediacy was removed as of [DATE] at 10:38 AM. The evidence is as follows:A review of the facility's Abuse Investigation and Reporting policy dated [DATE], included 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 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315355	A. Building B. Wing	03/06/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	to the person in charge of the investigation.4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of an investigation.Role of the Investigator: The Individual conducting the investigation will, as a minimum review the completed document forms; review the resident's medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. A review of the facility's Reportable Events Policy dated [DATE], included it is the policy of the facility to ensure that all reportable events, incidents, allegations, and operational disruptions that may impact the health, safety, or welfare of residents are promptly identified, investigated, documented, and reported to the appropriate regulatory authorities. Purpose: to establish a standardized process to.protect resident safety and welfare.Types of Reportable Events: resident safety events; allegations or suspicions of abuse, neglect, or exploitation. A review of the facility's Physician's Orders and Notifications policy dated [DATE], included; the facility will notify the resident's physician promptly for specified events and whenever there is a change in condition that may require medical assessment or treatment change.A. Events Requiring Prompt Notification (minimum): Notify the resident's attending physician promptly for the following (not exhaustive): acute change in mental status, new or worsened confusion, or sudden behavior changes.significant change in vital signs (blood pressure, heart rate, respiration rate) from baseline or defined thresholds.any event that may require [ER] transfer or hospital admission.B. timing Expectations: Immediate (within minutes - same shift): life-threatening or potentially life-threatening changes (respiratory compromise, hemodynamic instability, seizure). A review of the facility's Change in Condition Policy dated [DATE], included the purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notify, consistent with his or her authority, resident's representative when there is a significant change requiring notification. Situations requiring notification include: a significant change in the resident's physical, mental, or psychosocial status that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications: This includes: a. life-threatening conditions, or b. clinical complications. On [DATE] at 9:00 AM, the surveyor was informed by ADON #1, that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the hospital immediately on [DATE], for low blood pressure and the resident expired in the hospital that day. ADON #1 continued that ADON #2 was made aware by nursing of the resident's low blood pressure (BP), and ADON #2 called MD #1, who ordered the resident to be sent to the ER immediately. ADON #1 stated ADON #2 ignored the order and kept the resident in the facility because of the census numbers and administration pressure to keep residents in-house. ADON #1 stated that ADON #2 did not make herself or the Director of Nursing (DON) aware of the situation, and she had a history of going rogue and that ADON #2 felt she could provide the resident better treatment than in the hospital. ADON #1 stated that MD #1 came into the facility at 10:00 AM, for her scheduled rounds and at 10:10 AM, LPN #2 informed MD #1 that Resident #1 was still in the facility. MD #1 was upset and MD #1 immediately sent Resident #1 to the hospital who expired there that day. On [DATE] at 9:10 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #1. A review of the Face Sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses that included but were not limited to; systolic (congestive) heart failure (a condition in which the left ventricle of your heart is weak), atrial fibrillation (an irregular and often very rapid heart rhythm), and hypertension (high blood pressure). A review of the most recent Minimum Data Set (MDS), an assessment tool dated [DATE], indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating the resident had moderate cognitive impairment. A review of Resident #1's Vital Signs revealed on [DATE] at 8:54 AM, the resident's BP was 73/47 millimeters of mercury (mm Hg). (Normal range for adults 120/80 mm Hg and low blood pressure is lower than 90/60 mm Hg.) A review of the Progress (continued on next page)

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	03/06/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Notes included the following notes: A Nursing Progress Note dated [DATE] at 7:26 AM, documented by the Registered Nurse (RN #1), included the resident was observed with loose stools accompanied by very foul-smelling, dark fluid. The resident was encouraged to increase oral hydration and tolerated fluids. Oxygen saturation (SpO2, level of oxygen in the blood) remains at 95% on 2 lpm (two liters per minute) of oxygen via nasal cannula (NC). Will continue to monitor bowel output, hydration status, and overall condition. A Physician Progress Note dated [DATE] at 9:40 AM, documented Late Entry by MD #1, included: VERBAL ORDER at 9:33 AM GIVEN TO NURSING [ADON #2] TO SEND PATIENT OUT TO emergency room DUE TO LOW BLOOD PRESSURE. A Nursing Note dated [DATE] at 10:51 AM, documented by LPN #1, included during morning rounds, the resident was observed for changes in condition and vital signs. The resident was awake and responsive, but the resident appeared disoriented. Vital signs were taken; BP 71/47 mm Hg, heart rate (HR) 64 beats per minute (bpm), temperature (temp) 97.7 degrees Fahrenheit (F), respiration rate (RR) 18 breaths per minute (bpm), and SpO2 95% with oxygen being administered at 2 lpm via NC. [ADON #2] was made aware and received orders for STAT (immediate) labs, X-ray, and urine analysis. All orders were placed and [ADON #2] was waiting for a response from [MD #1]. A Provider Progress Note dated [DATE] at 10:54 AM, documented Late Entry by ADON #2 and created on [DATE] at 10:05 AM, included that the writer (ADON #2) was notified by the float nurse regarding the resident's condition. ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was responsive with no signs of labored breathing noted. The resident was repositioned for comfort, and [MD #1] was contacted unsuccessfully initially. The Director of Nursing (DON) was immediately notified for assessment, and MD #1 gave order to send out at 9:59 AM. Emergency services (911) was activated, and the resident remained responsive at the time of transfer. A Nursing Progress Note dated [DATE] at 12:36 PM, documented by LPN #2, included that [MD #1] arrived, and blood pressure was 63/36 mm Hg. They were unable to obtain SpO2 levels, and order recommended to send resident to ER due to change in condition. Emergency services (911) were called, and the resident was transported to the ER. A Nursing Progress Note dated [DATE] at 2:09 PM, documented by LPN #1, included that the resident was admitted to the ER with a diagnosis of unspecified shock (sudden drop in blood flow throughout the body leading to insufficient oxygen and nutrient supply to vital organs), anemia (low red blood cells which caused creased oxygen delivery in the blood), and hyperkalemia (abnormally high levels of potassium). A Physician's Progress Note dated [DATE] at 3:57 PM, included [the resident] was seen and examined at bedside.This morning noted to have hypotension (low blood pressure) and loose, foul-smelling dark stool per nursing. [The resident] appears more lethargic and intermittently disoriented. Denies chest pain or shortness of breath when aroused. Unable to provide detailed history due to mental status changes.Assessment and Plan.acute hypotension/suspected shock. Severe hypotension [systolic blood pressure (pressure when the heart beats) 60-70s] with altered mentation.911 activated to transfer to ER. A review of the Order Audit Report, included a telephone order dated [DATE] at 9:20 AM, to send the resident to the ER for emergency transfer due to change in condition. This order contradicted ADON #2's Late Entry note that they were unable to contact MD #1, and they did not receive an order to transfer the resident to the ER until 9:59 AM. On [DATE] at 10:40 AM, the surveyor interviewed MD #1, who stated on [DATE] at 9:30 AM, ADON #2 had called her regarding the resident's low BP. MD #1 stated she instructed ADON #2 to call 911 and send the resident to the ER. MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their BP had decreased to 64/34 mm Hg. MD #1 stated that LPN #2 informed her that we were told to wait until you came in. MD #1 spoke to ADON #2, who stated they were waiting on labs to be drawn prior to calling 911. MD #1 specified that the resident needed to be sent to the ER immediately and waiting for labs to be drawn was not appropriate for the resident's condition, and 911 was called. MD #1 stated it was an unfortunate event, and she was not sure if the (continued on next page)

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	03/06/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	DON or ADON #1 were made aware of the situation. On [DATE] at 10:50 AM, the surveyor interviewed the DON, who stated that the facility was not made aware of the situation with Resident #1 not being immediately sent to the hospital until after the resident expired. The DON continued that ADON #2 had not made her aware and it was a habit of ADON #2's. The DON stated that MD #1's orders to immediately send Resident #1 to the hospital should have been followed, and the facility had investigated the incident. The DON stated she had reviewed the resident's progress notes and she had observed a Late Entry progress note created by ADON #2 on [DATE], that was dated [DATE]. In that note, ADON #2 documented the DON was made aware of the resident's change in condition, but the DON stated it was not true. The DON stated that ADON #2 had written that note on [DATE], and immediately resigned and left the facility. The DON stated that the facility's corporate team was made aware on [DATE], and they conducted an investigation. The DON stated she was not interviewed. On [DATE] at 10:54 AM, the surveyor interviewed LPN #2, who stated LPN #1 obtained vital signs from Resident #1, and she informed her of the resident's change in condition. LPN #2 continued that they notified ADON #2, who checked the resident and ordered STAT labs, urine analysis, and X-ray, and stated she would notify MD #1. LPN #2 stated that she had returned to passing out morning medications, and she had asked ADON #2 if they were sending [the resident] out, and ADON #2 stated, we're waiting on the doctor. LPN #2 stated that MD #1 came in, and she informed MD #1 the resident's latest BP and that the resident was still in the building. LPN #2 stated she heard MD #1 say to send Resident #1 to the ER immediately. On [DATE] at 11:05 AM, the surveyor interviewed LPN #1, who stated on [DATE], she took Resident #1's vital signs. LPN #1 stated upon finding the resident had low BP, she notified ADON #2 and LPN #2 of the resident's low BP and change in condition. LPN #1 stated the resident was normally alert, but they were disoriented. LPN #1 stated that ADON #2 told her to order STAT labs and a chest X-ray, and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and LPN #2 took over. On [DATE] at 11:41 AM, the surveyor conducted a telephone interview with ADON #2, who stated, I contacted and alerted the DON and [MD #1] of the resident's condition. I initially spoke to the doctor at 9:30 AM, and [MD #1] stated to call 911. The surveyor asked ADON #2 why the resident had not been sent out until after 10:10 AM, and ADON #2 stated she did not recall. The surveyor then asked ADON #2 why nursing and MD #1 informed the surveyor that ADON #2 had told them to wait for MD #1 to come in, and ADON #2 did not respond. The surveyor then asked ADON #2 why she back dated two progress notes, and ADON #2 replied, I was told not to write a note on [DATE], by the Licensed Nursing Home Administrator (LNHA). I decided to write a note on the day I resigned, because it was the right thing to do. On [DATE] at 12:00 PM, the surveyor interviewed the LNHA, who stated that corporate did an investigation of the situation. The LNHA stated that the situation was brought up because ADON #1 and ADON #2 did not get along. The surveyor asked if there was a delay in the resident being sent to the ER, and the LNHA stated yes, it did seem that happened. At that time, the LNHA provided the surveyor with an undated document that had not resident's name on it, that the LNHA stated was the facility's complete investigation for the incident on [DATE]. A review of the undated and untitled document that was provided by the LNHA contained a one paragraph summary and a one paragraph conclusion with no resident's name, date of incident, or attached statements. The information provided was as follows: Summary: The patient was noted to have a low blood pressure reading during evaluation. Despite the hypotension, the patient remained responsive and alert. Vital signs showed a stable heart rate and adequate oxygen saturation throughout the assessment. The patient has a history of extensive comorbidities, which may contribute to fluctuations in blood pressure and overall clinical status. Monitoring and evaluation were maintained, staff communicated with physician and no immediate signs of respiratory distress or acute decompensation were observed at time of evaluation. Conclusion: Although the patient demonstrated hypotension, the presence of stable heart rate, normal oxygen saturation, and maintained responsiveness. Given the patient's significant comorbid conditions, close physician communication and monitoring and further medical evaluation (continued on next page)

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	03/06/2026

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	were recommended to determine the underlying cause of the low blood pressure and to guide appropriate management. Patient was sent to the emergency room via 911; [gender redacted] left the facility alert and responsive. An acceptable Removal Plan (RP) was received on [DATE] at 10:38 AM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the immediacy including; Resident #1 was sent to the hospital and expired there. On [DATE], the [NAME] President (VP) of Clinical Services and VP of Human Resources met with the DON to review and reinforce the facility's acute transfer review process, unit rounding procedures, and clinical oversight of residents experiencing an acute change in condition. On [DATE], the Chief Nursing met with the DON and reinforced expectations related to timely and accurate documentation, physician notification, and escalation of care when residents experience an acute change in condition. On [DATE], the LNHA and DON provided ongoing education to all licensed nursing staff on the following; physician notification of residents' changes in condition, documentation of physician's orders, carrying out a physician's order, change in condition assessment and emergency response, resident neglect, abuse, and prevention. The LNHA will provide ongoing oversight of the DON to ensure continued monitoring of changes in condition, physician/provider notification, and documentation of clinical interventions. ADON #2 no longer works for the facility, and the clinical team reviewed all sub-acute charts and there were no additional discrepancies identified. The surveyor verified the implementation of the Removal Plan on-site on [DATE], and determined the immediacy was removed as on [DATE] at 10:38 AM. During a post survey interview with the LNHA on [DATE] at 3:23 PM, the LNHA informed the surveyor that the facility misplaced Resident #1's Universal Transfer Form that was sent with the resident to the ER on [DATE]. The LNHA stated that the facility had contacted the hospital for a copy. N.J.A.C. 8:39-4.1(a)5; 27.1(a)

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	03/06/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to report an allegation of neglect to the New Jersey Department of Health (NJDOH). This deficient practice was identified for 1 of 3 residents reviewed for neglect (Resident #1), and was evidenced by the following:On [DATE] at 9:00 AM, the surveyor was informed by the Assistant Director of Nursing (ADON #1), that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the hospital on [DATE], for low blood pressure and a change in condition. ADON #1 continued that Resident #1's Medical Doctor (MD #1) came into the facility later that day, and MD #1 was upset that Resident #1 was still at the facility. ADON #1 stated that MD #1 immediately sent Resident #1 to the hospital, who expired there that day. On [DATE] at 9:10 AM, the surveyor reviewed Resident #1's Electronic Medical Record (EMR) A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; systolic (congestive) heart failure (a condition in which the left ventricle of your heart is weak), atrial fibrillation (an irregular and often very rapid heart rhythm) and hypertension (high blood pressure). A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident had moderate cognitive impairment. A review of Resident #1's Vital Signs revealed on [DATE] at 8:54 AM, the resident's blood pressure (BP) was 73/47 millimeters of mercury (mm Hg). (Normal range for adults 120/80 mm Hg and low blood pressure is lower than 90/60 mm Hg.) A review of the Progress Notes included the following notes: A Nursing Progress Note dated [DATE] at 7:26 AM, documented by the Registered Nurse (RN #1), included the resident was observed with loose stools accompanied by very foul-smelling, dark fluid. The resident was encouraged to increase oral hydration and tolerated fluids. Oxygen saturation (SpO2, level oof oxygen in the blood) remains at 95% on two liters per minute (2 lpm) of oxygen via nasal cannula (NC). Will continue to monitor bowel output, hydration status, and overall condition. A Physician Progress Note dated [DATE] at 9:40 AM, documented Late Entry by MD #1, included VERBAL ORDER at 9:33 AM GIVEN TO NURSING [ADON #2] TO SEND PATIENT OUT TO emergency room DUE TO LOW BLOOD PRESSURE. A Provider Progress Note dated [DATE] at 10:54 AM, documented Late Entry by ADON #2 and created on [DATE] at 10:05 AM, included that the writer (ADON #2) was notified by the float nurse regarding the resident's condition. ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was responsive with no signs of labored breathing noted. The resident was repositioned for comfort, and [MD #1] was contacted unsuccessfully initially. The Director of Nursing (DON) was immediately notified for assessment, and MD #1 gave order to send out at 9:59 AM. Emergency services (911) was activated, and the resident remained responsive at the time of transfer. On [DATE] at 10:40 AM, the surveyor interviewed MD #1, who stated on [DATE] at 9:30 AM, ADON #2 had called her regarding the resident's low BP. MD #1 stated she instructed ADON #2 to call 911 and send the resident to the ER. MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their BP had decreased to 64/34 mm Hg. MD #1 stated that LPN #2 informed her that we were told to wait until you came in. MD #1 spoke to ADON #2, who stated they were waiting on labs to be drawn prior to calling 911. MD #1 specified that the resident needed to be sent to the ER immediately and waiting for labs to be drawn was not appropriate for the resident's condition, and 911 was called. MD #1 stated it was an unfortunate event, and she was not sure if the DON or ADON #1 were made aware of the situation. On [DATE] at 10:50 AM, the surveyor interviewed the DON, who stated that the facility was not made aware of the (continued on next page)

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	03/06/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situation with Resident #1 not being immediately sent to the hospital until after the resident expired. The DON continued that ADON #2 had not made her aware and it was a habit of ADON #2's. The DON stated that MD #1's orders to immediately send Resident #1 to the hospital should have been followed, and the facility had investigated the incident. The DON stated she had reviewed the resident's progress notes and she had observed a Late Entry progress note created by ADON #2 on [DATE], that was dated [DATE]. In that note, ADON #2 documented the DON was made aware of the resident's change in condition, but the DON stated it was not true. The DON stated that ADON #2 had written that note on [DATE], and immediately resigned and left the facility. On [DATE] at 11:05 AM, the surveyor interviewed LPN #1, who stated on [DATE], she took Resident #1's vital signs. LPN #1 stated upon finding the resident had low BP, she notified ADON #2 and LPN #2 of the resident's low BP and change in condition. LPN #1 stated the resident was normally alert, but they were disoriented. LPN #1 stated that ADON #2 told her to order STAT labs and a chest X-ray, and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and LPN #2 took over. On [DATE] at 1:30 PM, the surveyor met with the LNHA, who stated the facility should have reported the event to the NJDOH. A review of the facility's Reportable Events Policy, dated [DATE], included it is the policy of the facility to ensure that all reportable events, incidents, allegations, and operational disruptions that may impact the health, safety, or welfare of residents are promptly identified, investigated, documented, and reported to the appropriate regulatory authorities. Purpose to establish a standardized process to.protect resident safety and welfare.Types of Reportable Events: resident safety events; allegations or suspicions of abuse, neglect, or exploitation. A review of the facility's Abuse Reporting and Investigating policy, dated [DATE], included 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 .An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately but no later than; two hours if the alleged violation involves abuse or has resulted in serious bodily injury; or twenty-four hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury . NJAC 8:39-4.1(a)5

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	03/06/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of pertinent documents, it was determined that the facility failed to thoroughly investigate an unexpected death of a resident who was transferred to the emergency room and expired the same day to rule out neglect. This deficient practice was identified for 1 of 3 residents reviewed for neglect (Resident #1), and was evidenced by the following:On [DATE] at 9:00 AM, the surveyor was informed by ADON #1, that ADON #2 did not carry out a physician's order (PO) to send Resident #1 to the hospital immediately on [DATE], for low blood pressure and the resident expired in the hospital that day. ADON #1 continued that ADON #2 was made aware by nursing of the resident's low blood pressure (BP), and ADON #2 called MD #1, who ordered the resident to be sent to the ER immediately. ADON #1 stated ADON #2 ignored the order and kept the resident in the facility because of the census numbers and administration pressure to keep residents in-house. ADON #1 stated that ADON #2 did not make herself or the Director of Nursing (DON) aware of the situation, and she had a history of going rogue and that ADON #2 felt she could provide the resident better treatment than in the hospital. ADON #1 stated that MD #1 came into the facility at 10:00 AM, for her scheduled rounds and at 10:10 AM, LPN #2 informed MD #1 that Resident #1 was still in the facility. MD #1 was upset and MD #1 immediately sent Resident #1 to the hospital who expired there that day. On [DATE] at 9:10 AM, the surveyor reviewed the Electronic Medical Record (EMR) for Resident #1. A review of the Face Sheet (an admission summary), revealed the resident was admitted to the facility with diagnoses that included but were not limited to; systolic (congestive) heart failure (a condition in which the left ventricle of your heart is weak), atrial fibrillation (an irregular and often very rapid heart rhythm), and hypertension (high blood pressure). A review of the most recent Minimum Data Set (MDS), an assessment tool dated [DATE], indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating the resident had moderate cognitive impairment. A review of Resident #1's Vital Signs revealed on [DATE] at 8:54 AM, the resident's BP was 73/47 millimeters of mercury (mm Hg). (Normal range for adults 120/80 mm Hg and low blood pressure is lower than 90/60 mm Hg.) A review of the Progress Notes included the following notes: A Nursing Progress Note dated [DATE] at 7:26 AM, documented by the Registered Nurse (RN #1), included the resident was observed with loose stools accompanied by very foul-smelling, dark fluid. The resident was encouraged to increase oral hydration and tolerated fluids. Oxygen saturation (SpO2, level oof oxygen in the blood) remains at 95% on two liters per minute (2 lpm) of oxygen via nasal cannula (NC). Will continue to monitor bowel output, hydration status, and overall condition. A Physician Progress Note dated [DATE] at 9:40 AM, documented Late Entry by MD #1, included VERBAL ORDER at 9:33 AM GIVEN TO NURSING [ADON #2] TO SEND PATIENT OUT TO emergency room DUE TO LOW BLOOD PRESSURE. A Nursing Note dated [DATE] at 10:51 AM, documented by LPN #1, included during morning rounds, the resident was observed for changes in condition and vital signs. The resident was awake and responsive, but the resident appeared disoriented. Vital signs were taken; BP 71/47 mm Hg, heart rate (HR) 64 beats per minute (bpm), temperature (temp) 97.7 degrees Fahrenheit (F), respiration rate (RR) 18 breaths per minute (bpm), and SpO2 95% with oxygen being administered at 2 lpm via NC. [ADON #2] was made aware and received orders for STAT (immediate) labs, X-ray, and urine analysis. All orders were placed and [ADON #2] was waiting for a response from [MD #1]. A Provider Progress Note dated [DATE] at 10:54 AM, documented Late Entry by ADON #2 and created on [DATE] at 10:05 AM, included that the writer (ADON #2) was notified by the float nurse regarding the resident's condition. ADON #2 entered the resident's room together with the float nurse to see the resident. Vital signs were obtained, and the resident was responsive with no signs of labored breathing noted. The resident was repositioned for comfort, and [MD #1] was contacted unsuccessfully initially. The Director of Nursing (DON) was immediately notified for assessment, and MD #1 gave order to send out at 9:59 AM. Emergency services (911) was activated, and the resident (continued on next page)

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	03/06/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remained responsive at the time of transfer. A Nursing Progress Note dated [DATE] at 12:36 PM, documented by LPN #2, included that [MD #1] arrived, and blood pressure was 63/36 mm Hg. They were unable to obtain SpO2 levels, and order recommended to send resident to ER due to change in condition. Emergency services (911) were called, and the resident was transported to the ER. A Nursing Progress Note dated [DATE] at 2:09 PM, documented by LPN #1, included that the resident was admitted to the ER with a diagnosis of unspecified shock (sudden drop in blood flow throughout the body leading to insufficient oxygen and nutrient supply to vital organs), anemia (low red blood cells which caused creased oxygen delivery in the blood), and hyperkalemia (abnormally high levels of potassium). A Physician's Progress Note dated [DATE] at 3:57 PM, included [the resident] was seen and examined at bedside.This morning noted to have hypotension (low blood pressure) and loose, foul-smelling dark stool per nursing. [The resident] appears more lethargic and intermittently disoriented. Denies chest pain or shortness of breath when aroused. Unable to provide detailed history due to mental status changes.Assessment and Plan.acute hypotension/suspected shock. Severe hypotension [systolic blood pressure (pressure when the heart beats) 60-70s] with altered mentation.911 activated to transfer to ER. A review of the Order Audit Report included a telephone order dated [DATE] at 9:20 AM, to send the resident to the ER for emergency transfer due to change in condition. This order contradicted ADON #2's Late Entry note that they were unable to contact MD #1, and they did not receive an order to transfer the resident to the ER until 9:59 AM. On [DATE] at 10:40 AM, the surveyor interviewed MD #1, who stated on [DATE] at 9:30 AM, ADON #2 had called her regarding the resident's low BP. MD #1 stated she instructed ADON #2 to call 911 and send the resident to the ER. MD #1 further stated she arrived at the facility at 10:00 AM for scheduled rounds of her residents, and she was under the assumption that Resident #1 had left the facility. MD #1 continued at 10:10 AM, she was told by LPN #2 that the resident was still in the facility, and their BP had decreased to 64/34 mm Hg. MD #1 stated that LPN #2 informed her that we were told to wait until you came in. MD #1 spoke to ADON #2, who stated they were waiting on labs to be drawn prior to calling 911. MD #1 specified that the resident needed to be sent to the ER immediately and waiting for labs to be drawn was not appropriate for the resident's condition, and 911 was called. MD #1 stated it was an unfortunate event, and she was not sure if the DON or ADON #1 were made aware of the situation. On [DATE] at 10:50 AM, the surveyor interviewed the DON, who stated that the facility was not made aware of the situation with Resident #1 not being immediately sent to the hospital until after the resident expired. The DON continued that ADON #2 had not made her aware and it was a habit of ADON #2's. The DON stated that MD #1's orders to immediately send Resident #1 to the hospital should have been followed, and the facility had investigated the incident. The DON stated she had reviewed the resident's progress notes and she had observed a Late Entry progress note created by ADON #2 on [DATE], that was dated [DATE]. In that note, ADON #2 documented the DON was made aware of the resident's change in condition, but the DON stated it was not true. The DON stated that ADON #2 had written that note on [DATE], and immediately resigned and left the facility. The DON stated that the facility's corporate team was made aware on [DATE], and they conducted an investigation. The DON stated she was not interviewed. On [DATE] at 10:54 AM, the surveyor interviewed LPN #2, who stated LPN #1 obtained vital signs from Resident #1, and she informed her of the resident's change in condition. LPN #2 continued that they notified ADON #2, who checked the resident and ordered STAT labs, urine analysis, and X-ray, and stated she would notify MD #1. LPN #2 stated that she had returned to passing out morning medications, and she had asked ADON #2 if they were sending [the resident] out, and ADON #2 stated, we're waiting on the doctor. LPN #2 stated that MD #1 came in, and she informed MD #1 the resident's latest BP and that the resident was still in the building. LPN #2 stated she heard MD #1 say to send Resident #1 to the ER immediately. On [DATE] at 11:05 AM, the surveyor interviewed LPN #1, who stated on [DATE], she took Resident #1's vital signs. LPN #1 stated upon finding the resident had low BP, she notified ADON #2 and LPN #2 of the resident's low BP and change in condition. LPN #1 stated the resident was normally alert, but they (continued on next page)

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	03/06/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were disoriented. LPN #1 stated that ADON #2 told her to order STAT labs and a chest X-ray, and that she would contact MD #1. LPN #1 stated she was floating on two nursing floors and ADON #2 and LPN #2 took over. On [DATE] at 11:41 AM, the surveyor conducted a telephone interview with ADON #2, who stated, I contacted and alerted the DON and [MD #1] of the resident's condition. I initially spoke to the doctor at 9:30 AM, and [MD #1] stated to call 911. The surveyor asked ADON #2 why the resident had not been sent out until after 10:10 AM, and ADON #2 stated she did not recall. The surveyor then asked ADON #2 why nursing and MD #1 informed the surveyor that ADON #2 had told them to wait for MD #1 to come in, and ADON #2 did not respond. The surveyor then asked ADON #2 why she back dated two progress notes, and ADON #2 replied, I was told not to write a note on [DATE], by the Licensed Nursing Home Administrator (LNHA). I decided to write a note on the day I resigned, because it was the right thing to do. On [DATE] at 12:00 PM, the surveyor interviewed the LNHA, who stated that corporate did an investigation of the situation. The LNHA stated that the situation was brought up because ADON #1 and ADON #2 did not get along. The surveyor asked if there was a delay in the resident being sent to the ER, and the LNHA stated yes, it did seem that happened. At that time, the LNHA provided the surveyor with an undated document that had not resident's name on it, that the LNHA stated was the facility's complete investigation for the incident on [DATE]. A review of the undated and untitled document that was provided by the LNHA contained a one paragraph summary and a one paragraph conclusion with no resident's name, date of incident, or attached statements. The information provided was as follows: Summary: The patient was noted to have a low blood pressure reading during evaluation. Despite the hypotension, the patient remained responsive and alert. Vital signs showed a stable heart rate and adequate oxygen saturation throughout the assessment. The patient has a history of extensive comorbidities, which may contribute to fluctuations in blood pressure and overall clinical status. Monitoring and evaluation were maintained, staff communicated with physician and no immediate signs of respiratory distress or acute decompensation were observed at time of evaluation. Conclusion: Although the patient demonstrated hypotension, the presence of stable heart rate, normal oxygen saturation, and maintained responsiveness. Given the patient's significant comorbid conditions, close physician communication and monitoring and further medical evaluation were recommended to determine the underlying cause of the low blood pressure and to guide appropriate management. Patient was sent to the emergency room via 911; [gender redacted] left the facility alert and responsive. A review of the facility's Abuse Investigation and Reporting policy, dated [DATE], included 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.4. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of an investigation.Role of the Investigator: The Individual conducting the investigation will, as a minimum review the completed document forms; review the resident's medical record to determine events leading up to the incident; interview the person(s) reporting the incident; interview any witnesses to the incident; interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident. A review of the facility's Reportable Events Policy, dated [DATE], included it is the policy of the facility to ensure that all reportable events, incidents, allegations, and operational disruptions that may impact the health, safety, or welfare of residents are promptly identified, investigated, documented, and reported to the appropriate regulatory authorities .6. (continued on next page)

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	03/06/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Investigation Process. The facility will initiate an investigation within twenty-four hours of the reportable event. the investigation includes: interviewing staff involved and witnesses; reviewing medical records and care plans; evaluating contributing factors. 7. Root Cause Analysis (RCA). For serious events, the facility will conduct RCA to identify: system failures, environmental factors, staff training gaps, policy or procedural deficiencies. The RCA must include corrective actions and prevention strategies . N.J.A.C. 8:39-4.1(a)5