

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2025
NAME OF PROVIDER OR SUPPLIER Excel Care at Wayne		STREET ADDRESS, CITY, STATE, ZIP CODE 296 Hamburg Turnpike Wayne, NJ 07470	

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 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. (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

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint # 265013 Based on interviews and review of other pertinent facility documents on 10/27/2025 and 10/29/2025, it was determined that the facility failed to ensure the nursing staff documented a resident's (Resident #2) elopement from the facility in the resident's medical record in accordance with professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed for elopement (Resident #2). Reference: New Jersey Statutes, Annotated Title 45 Chapter 11, Nursing Board. The Nurse Practice Act for the State of New Jersey states; the practice of nursing as a Registered Professional Nurse is defined as diagnosing, and treating human response to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized Physician or dentist. Reference: 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 otherwise legally authorized Physician or Dentist. The evidence was as follows: A review of the Facility Reportable Event (FRE) dated 10/19/2025, that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that on 10/19/2025, at approximately 2:40 PM, Resident #2 was noted not to be in their room after the resident was last seen at the nurse's station at approximately 2:30 PM. An elopement protocol was initiated, and the search was initiated inside the facility. While the search was happening, a visiting family member (VF #1) [of another resident] stated that she saw a [gender redacted] walking outside the facility. The facility staff prompted a prioritized search outside of the facility and found Resident #2 in the company of a person who noticed the resident outside the facility. At approximately 2:45 PM, the resident was brought back to the facility, and their wander guard was noted to be fully functional. A skin assessment was completed, and no visible injuries were noted. At 3:00 PM, Resident #2's doctor and family were notified, and the resident was placed on one-to-one (1:1) supervision. According to the admission Record face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to; dementia, epilepsy, and history of falling. According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 10/15/2025, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated the resident's cognition was severely impaired. A review of Resident #2's Care Plan (CP) with an initiated date of 10/15/2025, revealed that the resident had a potential risk for elopement related to (r/t) wandering and potential for injury. The CP also indicated that Resident #2 had a wander guard placed on their left wrist and that the resident should be engaged in purposeful activity. A review of Resident #2's Progress Notes included a Nurse's Progress Note dated 10/20/2025 at 12:00 PM, with an effective date of 10/19/2025 at 4:00 PM, written by the Licensed Practical Nurse (LPN #3) included that the resident's Skin warm and dry, skin color within normal limit (WNL) and turgor is normal. Resident does not have an external device. 1. Foot evaluation completed. The Progress Notes did not include any documentation that the resident eloped from the facility on 10/19/2025. During an interview with LPN #1 on 10/27/2025 at 11:19 AM, she stated that at approximately 2:30 PM, the resident was walking around back and forth by the nurse's station. LPN #1 stated that the assigned nurse (LPN #3) gave her the keys to LPN #3's medication cart because LPN #3 was going on break. LPN #1 stated that Resident #2 complained they had a headache and she was going to give the resident a Tylenol. LPN #1 stated when she went to Resident #2's room, the resident was not there. LPN #1 stated that she checked the hallway and did not find the resident, so she paged all staff to come to the First-Floor nursing unit. LPN #1 stated that as staff came, VF #1 of a different resident told her that they just saw a [gender retracted] outside wearing [sleepwear]. LPN #1 stated that she, along with the other staff members, ran outside and ran for about 1-2 minutes, and there was VF #2 sitting by the gazebo on the facility's property that told them that the resident went that way (pointing to the right). LPN #1 stated that they found the resident a block down on the right standing on the sidewalk with two women who stated that the resident looked out of place with [sleepwear] on. LPN #1 stated that the resident was brought back inside the building and the assigned nurse (LPN #3) assessed the resident and there were no injuries. During an interview on 10/27/2025 at 5:04 PM, with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the [NAME] President of Clinical (VPC), the surveyor asked what should be documented in the resident's medical record in accordance with professional standards of practice. The DON stated falls</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: 2650138 Based on observation, interviews, review of medical records, and review of other pertinent facility documents on 10/27/2025 and 10/29/2025, it was determined that the facility failed to provide adequate supervision to a severely cognitively impaired resident (Resident #2) with a known history of wandering and wore a wander guard, who eloped from the facility on 10/19/2025. The deficient practice was identified for 1 of 4 residents reviewed for elopement (Resident #2). On 10/19/2025 at approximately 2:30 PM, the Licensed Practical Nurse (LPN #1) noticed Resident #2 was not in their room, and she could not find the resident. LPN #1 initiated a search, and a visiting family (VF #1) of another resident stated that they observed a [gender redacted] outside wearing [sleepwear], and LPN #1 and other staff immediately went outside to search for Resident #2. While outside the facility, VF #2, who was at the facility's gazebo next to a winding downhill paved foot path, directed the staff to search down towards the highway to the right. LPN #1 stated during an interview with the surveyor on 10/27/2025, that the resident was found on the sidewalk approximately one block away in the company of two women who stated the resident looked out of place wearing [sleepwear]. The resident was returned to the facility immediately at approximately 2:45 PM, assessed with no injury, and placed on one-to-one (1:1) supervision. The facility's failure to provide adequate supervision to a severely cognitively impaired resident who was at risk for elopement and eloped, placed Resident #2 as well as all residents, at risk for elopement. This posed a likelihood of serious harm, injury, impairment, or death and resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 10/19/2025 at approximately 2:30 PM, after Resident #2 was last seen by staff in the facility. The facility Administration was notified of the IJ on 10/27/2025 at 5:15 PM. The facility submitted an acceptable Removal Plan (RP) on 10/28/2025 at 12:30 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on 10/29/2025. The facility further failed to b.) ensure all staff were able to identify a resident (Resident #4) who was a wanderer to provide adequate supervision to prevent elopement. This deficient practice was identified for 1 of 4 residents reviewed for elopement (Resident #4). The evidence was as follows:Part A</p> <p>A review of the facility provided Elopement Policy and Procedure dated 6/1/2025, included It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practicable . Procedure .9 d. In the event that there is any doorway equipment malfunction, supervision of that area will be provided unless there is only one resident at risk in which case the assigned staff member will provide 1:1 or other frequency or observation to the resident as determined by the physician or supervisor .</p> <p>A review of the facility provided Wanderguard Use Policy dated 5/1/2025, included the facility will provide safe, resident-centered, and regulatory-compliant guidance for the electronic wander management systems (e.g. Wanderguard) to prevent elopement. Maintenance, Testing, and Security 1. Maintenance staff or vendor shall perform proof scheduled preventative maintenance and immediate repairs . 2. Test system functionality per facility schedule and after any power outage, building work, or reported malfunction.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the Facility Reportable Event (FRE) dated 10/19/2025, that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that on 10/19/2025, at approximately 2:40 PM, Resident #2 was noted not to be in their room after the resident was last seen at the nurse's station at approximately 2:30 PM. An elopement protocol was initiated, and the search was initiated inside the facility. While the search was happening, a visiting family member (VF #1) [of another resident] stated that she saw a [gender redacted] walking outside the facility. The facility staff prompted a prioritized search outside of the facility and found Resident #2 in the company of a person who noticed the resident outside the facility. At approximately 2:45 PM, the resident was brought back to the facility, and their wanderguard was noted to be fully functional. A skin assessment was completed, and no visible injuries were noted. At 3:00 PM, Resident #2's doctor and family were notified, and the resident was placed on one-to-one (1:1) supervision.</p> <p>A review of LPN #1's statement included that she saw Resident #2 at approximately 2:30 PM, ambulating by the nurse's station, and at approximately 2:40 PM, she checked, and Resident #2 was not in their room. LPN #1 stated that she paged all staff to the First-Floor and all staff arrived. LPN #1 further stated that she was informed there was a [gender redacted] walking outside. LPN #1 stated that she and the staff ran outside and found the resident outside of the facility and brought the resident back into the facility. LPN #1 noted the resident's wanderguard alarmed when the resident re-entered the building.</p> <p>During an interview with the Licensed Nursing Home Administrator (LNHA) on 10/27/25 at 10:36 AM, he stated that there were no cameras, and that he was not sure of the exact route the resident took, but he surmised that Resident #2 went down the hallway on the First-Floor nursing unit, through the unzipped plastic construction dust barrier, then through the unlocked double doors into the dining and therapy area that were closed for renovations, and out an unsecured back door. The LNHA stated that he surmised that was the route of exit since all other exit doors' wanderguard systems were functioning and the receptionist at the main entrance denied seeing Resident #2 exit or hearing the wanderguard system alarm. The LNHA stated the wanderguard pin pad at the back door was not operational at that time, and the lights on the wanderguard pin pad were off when Resident #2 exited.</p> <p>At that time, the LNHA guided the surveyors through the now zipped plastic dust barrier, through the double doors, into the construction area and out the back door. While outside, the LNHA took the surveyors to the right on a path that led to a courtyard with a gate that accessed the facility's front driveway. The LNHA stated that he thought Resident #2 traveled that path, and the facility had now secured that gate with a chain lock.</p> <p>When the LNHA was bringing the surveyors back into the building from the back exit door, the surveyor observed an opening approximately two-feet wide from the building to [NAME]. The LNHA stated that since the ground beneath the opening was uneven rocks, he did not assume the resident went that way.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>At that time, the surveyors and the LNHA went through the opening, which led to the back of the building and around the dumpster/loading area, to the front parking lot area. In that area, the surveyor observed a gazebo on top of a hill with a winding paved foot path to the right, that led the surveyors down a wooded hill area that had a fallen tree trunk blocking the path approximately half-way down to the sidewalk at the roadside. The LNHA stated the tree trunk had fallen that past weekend and was not yet cleared. Towards the end of the path was a pond, and the path ended on a sidewalk adjacent to a four-lane highway. The surveyor asked the LNHA how far the facility was to the sidewalk, and the LNHA stated approximately the length of a football field.</p> <p>During an interview with LPN #2, who identified himself as the unit manager, on 10/27/2025 at 11:02 AM, he stated that on 10/15/2025, he observed Resident #2 for a while wandering in and out of the residents' rooms, and up and down the hallways aimlessly. LPN #2 stated that he assessed Resident #2 as an elopement risk and placed a wanderguard on the resident.</p> <p>During an interview with LPN #1 on 10/27/2025 at 11:19 AM, she stated that at approximately 2:30 PM, the resident was walking around back and forth by the nurse's station. LPN #1 stated that the assigned nurse (LPN #3) gave her the keys to LPN #3's medication cart because LPN #3 was going on break. LPN #1 stated that Resident #2 complained they had a headache, and she was going to give the resident a Tylenol. LPN #1 stated when she went to Resident #2's room, the resident was not there. LPN #1 stated that she checked the hallway and did not find the resident, so she paged all staff to come to the First-Floor nursing unit. LPN #1 stated that as staff came, VF #1 of a different resident told her that they just saw a [gender redacted] outside wearing [sleepwear]. LPN #1 stated that she, along with the other staff members, ran outside and ran for about 1-2 minutes, and there was VF #2 sitting by the gazebo on the facility's property that told them that the resident went that way (pointing to the right). LPN #1 stated that they found the resident a block down on the right standing on the sidewalk with two women who stated that the resident looked out of place standing there wearing [sleepwear]. LPN #1 stated that resident was brought back inside the building and the assigned nurse (LPN #3) assessed the resident and there were no injuries.</p> <p>During an interview with the Director of Maintenance (DM) on 10/27/2025 at 11:54 AM, he stated that there was a malfunction on the wanderguard pin pad by the exit door in the therapy room construction area. The DM stated that the wanderguard pin pad usually had a red and green light on, and when he got there, no lights were lit, and the power for the magnet lock was disconnected. The DM stated that he extended the wire and tightened the screws to fix the pin pad connection. The DM further stated that when Resident #2 pushed on the door, the alarm should have alarmed to notify the nurses at the nurse's station that someone with a wanderguard exited. The DM stated that he checked all the exit doors and elevators daily on Monday through Friday, and the Manager on Duty (MOD) checked them on Saturdays and Sundays. The DM stated on the day of the elopement, the MOD had not yet checked the alarms, so he had checked the alarms that day when the DM arrived after the elopement.</p> <p>During interview with the Housekeeping Director (HD) on 10/27/2025 at 2:11 PM, he confirmed he was the MOD on 10/19/2025. The HD stated that on 10/19/2025, he was busy that day and did not get to check the door prior to Resident #2 eloping.</p> <p>The surveyor reviewed the medical record for Resident #2.</p> <p>According to the admission Record face sheet, Resident #2 was admitted to the facility with diagnosis which included but were not limited to; dementia, epilepsy, and history of falling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>According to the comprehensive Minimum Data Set (MDS), an assessment tool dated 10/15/2025, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 4 out of 15, which indicated the resident's cognition was severely impaired.</p> <p>A review of Resident #2's Elopement Evaluation dated 10/15/2025 at 2:01 PM, included that Resident #2 wandered, wandered aimlessly or non-goal directed, and wandering behavior likely to effect the safety or well-being of self/others. Resident #2 scored 5, and a score of 1 or higher indicated a risk of elopement on the assessment.</p> <p>A review of Resident #2's Care Plan (CP) with an initiated date of 10/15/2025, included that Resident #2 had the potential risk for elopement related to (r/t) wandering and potential for injury. The CP also indicated that Resident #2 had a wanderguard placed on the resident's left wrist and that the resident should be engaged in purposeful activity.</p> <p>A review of the Progress Note (PN) dated 10/20/2025 at 12:00 PM, with an effective date of 10/19/2025 at 4:00 PM, written by LPN #3, included, Skin warm and dry, skin color within normal limit (WNL) and turgor is normal. The resident does not have an external device. 1. Foot evaluation completed. There was no documentation of Resident #2's elopement.</p> <p>A review of the PN dated late entry on 10/21/2025 at 12:21 PM, with an effective date of 10/15/2025 at 3:13 PM, written by LPN #2, included, Resident was noted to be wandering in other residents' rooms disturbing them, going behind and pulled curtain. Resident redirected out of the room. Resident then proceeded to go to another resident's room and try to open the bathroom door. Resident noted to have increased wandering. Elopement risk reassessed and wanderguard applied.</p> <p>On 10/29/2025 at 12:56 PM, the surveyor attempted to conduct a telephone interview with LPN #3, who did not answer. LPN #3 did not return the surveyor's telephone call, and she was not present during the survey for an interview.</p> <p>An acceptable Removal Plan (RP) was received on 12/28/2025 at 12:29 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: on 10/19/2025, Resident #2 was located and brought back in building, wanderguard was functional, the resident was assessed with no injuries and placed on 1:1 supervision. On 10/19/2025, the DM checked doors, elevators, and wanderguard systems to confirm functional, and identified a possible exit in a non-residential area and secured with alarm. On 10/19/2025, the facility began an investigation, and wanderguard devices were tested. On 10/27/2025, the Neighborhood Watch list with residents' photos was updated, an elopement drill was conducted, Certified Nursing Aide (CNA) assignments were updated to include identification of residents at risk for elopement, and all staff were educated on elopement process.</p> <p>The surveyor verified the implementation of the Removal Plan on-site on 10/29/2025, and determined the immediacy was removed as of 10/29/2025 at 2:00 PM.</p> <p>Part B</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/27/2025 at 9:57 AM, the surveyor interviewed the Assistant Director of Nursing (ADON), who identified herself as the unit manager for the Second-Floor nursing unit. The ADON stated that the facility used a Neighborhood Watch list that identified who was at risk for elopement that was hung at the nurse's station. At that time, the ADON provided a list from the nurse's station that included three residents (Resident #1, Resident #2, and Resident #3), who were identified as at risk for elopement.</p> <p>On 10/27/2025 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2), who identified himself as the unit manager. LPN #2 stated that there were no residents residing on the First-Floor nursing unit who were an elopement risk. At that time, the surveyor observed a Neighborhood Watch list hanging at the nurse's station that included four residents (Resident #1, Resident #2, Resident #3, and Resident #4) with their room numbers.</p> <p>On 10/27/2025 at 10:55 AM, the surveyor observed Resident #4's name was still listed on the name plate outside their assigned room.</p> <p>On 10/27/2025 at 11:07 AM, the surveyor requested from the Director of Nursing (DON) to test the three residents' wanderguard bracelets for function. At that time, the surveyor observed the DON select Resident #1, Resident #2, and Resident #3, and he tested their wanderguard, and they all functioned. The DON did not ask which three residents and did not mention any additional residents who may have wanderguards including Resident #4.</p> <p>The surveyor reviewed the medical record for Resident #4.</p> <p>A review of the admission Record face sheet revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; syncope and collapse (falling due to fainting), unspecified fall, contusion (bruise) to scalp, and hypertension (high blood pressure).</p> <p>A review of the Progress Notes included a Social Services note dated 10/23/2025 at 11:43 AM, that the resident was admitted to the facility on [DATE redacted] from home for subacute rehabilitation. The resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, [which indicated a severely impaired cognition]. The resident was verbal and able to express some of their needs to staff.</p> <p>An additional review of the Progress Notes included a Nurses Progress Note dated 10/23/2025 at 10:29 PM, that the resident was noted with increased wandering and attempting to open doors. A wanderguard was applied and the family was notified who was aware of wandering behaviors and agreed to a room change.</p> <p>A review of the Order Listing Report included a physician's order dated 10/23/2025, for a wanderguard to left ankle, check placement every shift.</p> <p>A review of the Care Plan (CP) included a focus area dated 10/23/2025, that the resident was an elopement risk with regards to wandering. Interventions included to engage resident in purposeful activity; identify wandering/elopement de-escalation behaviors; provide care in a calm and reassuring manner; provide reorientation to surroundings, environment; and resident to have wanderguard to left ankle.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/27/2025 at 12:36 PM, the surveyor observed the Neighborhood Watch sign at the Second-Floor nursing unit now included four residents (Resident #1, Resident #2, Resident #3, and Resident #4).</p> <p>On 10/27/2025 at 12:37 PM, the surveyor interviewed Resident #4's Certified Nursing Aide (CNA #1), who stated that Resident #4 was new to the unit and had no behavioral issues. CNA #1 stated that the resident self-propelled in a wheelchair, and that he checked on the resident when he checked on Resident #4's roommate who was a wanderer. CNA #1 stated that Resident #4 was not a wanderer and did not wear a wanderguard. CNA #1 stated that the facility had three residents who wandered and named (Resident #1, Resident #2, and Resident #3). When asked how he was informed who was a wanderer, CNA #1 stated that staff informed him.</p> <p>On 10/27/2025 at 12:52 PM, the surveyor interviewed LPN #4, who cared for Resident #4. LPN #4 confirmed Resident #4 self-propelled in their wheelchair and wore a wanderguard bracelet on their left ankle that she checked every shift for placement. At that time, the surveyor observed Resident #4 lying bed. LPN #4 showed the surveyor the resident's wanderguard bracelet that was on their left ankle.</p> <p>On 10/27/2025 at 1:00 PM, the surveyor re-interviewed the ADON, who stated that the resident was moved up to the unit during the evening shift on Friday (10/24/2025, medical record indicated the resident was moved on 10/23/2025). The ADON confirmed it would be important that both the staff and she were aware of all the residents who were wanderers. The ADON stated that during morning huddle, staff were made aware of who the residents that wandered were. The ADON further stated that there was a new Neighborhood Watch sign that included all four residents at the nurse's station, but it was not hung earlier. At that time, the surveyor requested the ADON inform the DON that they wanted to test the function of Resident #4's wanderguard bracelet.</p> <p>On 10/27/2025 at 1:19 PM, the DON tested Resident #4's wanderguard bracelet for function. At that time, the surveyor asked the DON why he did not test Resident #4's wanderguard earlier, and the DON stated because the surveyor only requested three residents' wanderguard bracelets tested. The surveyor stated that they did not specify which three residents so how did the DON determine which residents the surveyor wanted tested. The DON stated that it slipped my mind when asked for three, and I forgot there was a fourth. When the surveyor questioned the DON that he forgot, the DON sated he did not forget, I misremembered. The DON stated that there were originally three residents who wandered, and Resident #4 was recently added.</p> <p>On 10/27/2025 at 5:04 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and the [NAME] President of Clinical (VPC), and the DON stated that the nurses identified someone at risk for elopement and placed a wanderguard bracelet on them. The DON continued that the Receptionist updated the facility's Neighborhood Watch list, and during morning meeting with the department heads, they were made aware of any changes. At that time, the surveyor informed the facility about their observation of the Neighborhood Watch list with three residents only and that staff were unaware Resident #4 was at risk for elopement.</p> <p>NJAC 8:39-27.1 (a)</p>		