STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at Wayne	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Complaint #2713977Based on observation, interview, and record review, it was determined that the facility failed to maintain accurately documented, complete and readily accessible medical records. This deficient practice was identified for 1 of 22 residents (Resident #125) reviewed.On 5/18/26 at 9:09AM, the surveyor reviewed the electronic medical record (EMR) of Resident #125. The resident no longer resided at the facility.The admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to urinary tract infection, acute on chronic congestive heart failure (a condition where the heart muscle is too weak or stiff to pump blood efficiently), and polyosteoarthritis (chronic degenerative joint disease in which the tissues in the joint wears down in five or more joints at the same time).A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 12/1/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #125 scored 15 out of 15, which indicated the resident was cognitively intact. Resident #125 was coded as dependent on assistance for toileting hygiene; required substantial/maximum assistance with personal hygiene and transferring; and was frequently incontinent of bladder. A review of a physician progress note, by the primary medical doctor (PMD) dated 1/9/26 at 4:06 PM documented Resident #125 had a right shin hematoma and was unaware if they hit it on something; the area was tender but now it was better. In addition, the note documented the resident was last seen by the PMD two days ago, marked, now looks less bluish, smaller, instructed for leg elevation, ice pack, avoid physical contact to the site. The PMD documented they discussed with Resident #125's [relation to the resident] at the bedside. A review of progress notes for January 2026 revealed no nursing documentation regarding the resident sustaining a right shin hematoma or notification to the PMD or emergency contact (EC).On 5/18/26 at 1:00 PM, the surveyor requested from the Director of Nursing (DON), any investigations for Resident #125 for January 2026. The DON stated they were not the DON in January 2026 and would review facility records to provide the requested information. On 5/19/26 at 9:24 AM, the surveyor reviewed the facility provided investigation dated 1/6/26, which indicated during rounds the (former) DON was notified the resident was found with a right shin hematoma. The documents included a summary of the investigation including written staff statements; an assessment of the resident's status; a review of potential causes and risk factors; and a conclusion. The investigation under notification revealed notified resident representative written as [relation to the resident]. There was no documented name of the EC, date or time of notification.There was no documentation found in the resident's medical record to indicate notification to the resident's EC regarding their right shin hematoma in January 2026.On 5/19/26 at 10:48 AM, the surveyor interviewed a Registered Nurse (RN) who cared for Resident #125. The RN stated they recalled the resident had a discoloration, like a blood filled blister but could not recall more details of what had occurred during that time. The RN acknowledged that if there was a change in a resident's status, their EC/resident representative should be notified, and it should be documented by the nurse.On 5/19/26 at 1:12 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) of the concern there was no documentation of (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification to Resident #125's EC regarding the right shin hematoma and there was no nursing documentation related to the right shin hematoma.The surveyor additionally requested for review a copy of December 2025 and January 2026 Resident #125's Tasks documentation report, a record where the CNA's document and sign for care provided to the residents.On 5/20/26 at 11:02 AM, the LNHA and the DON met with the survey team. The DON stated on the investigation provided documented notification to Resident #125's EC. The DON with the surveyor reviewed the investigation document which indicated the [relation to the resident] was notified. The DON confirmed there was no name of the person notified, no date, and no time of the notification.The surveyor asked the DON if the investigation was considered part of Resident #125's medical record. The DON replied that it was not part of the resident's medical record. The surveyor informed the DON that there was no documentation in the EMR by the nurses about the hematoma being identified or notification to an emergency contact. There was no verbal response at this time.On 5/20/26 at 12:20 PM, the surveyor interviewed over the phone an RN supervisor who worked at the facility in January 2026. The RN supervisor stated that if an injury of unknown origin, such as a discoloration or hematoma identified, part of the reporting and investigating process would be to notify the resident's EC/resident representative. The RN supervisor acknowledged that notification to the EC should be documented in a progress note in the EMR. The RN supervisor stated that even if a resident was cognitively intact, the EC would be made aware of a resident's status change or condition.On 5/21/26 at 9:13 AM, the surveyor reviewed the facility provided December 2025 (CNA tasks) Documentation Survey Report which revealed unsigned and blank entries. The entries included but were not limited to:-The entry for bladder elimination had 37 of 93 shift entries which were blank and unsigned.-The entry for bowel elimination had 37 of 93 shift entries which were blank and unsigned. -The entry for toileting hygiene had 37 of 93 shift entries which were blank and unsigned. The surveyor reviewed the facility provided January 2026 (CNA tasks) Documentation Survey Report which revealed unsigned and blank entries. The entries included but were not limited to:-The entry for bladder elimination had 15 of 29 shift entries which were left blank and unsigned.- The entry for bowel elimination had 15 of 29 shift entries which were left blank and unsigned.-The entry for toileting hygiene had 15 of 29 shift entries which were left blank and unsigned.On 5/21/26 at 1:24 PM, the surveyor informed the LNHA of the concerns of unsigned and blank entries for Resident #125's December 2025 and January 2026 documentation survey report. There was no additional information provided by the facility. The surveyor reviewed the undated facility provided policy titled Change in a Resident's Condition or Status which revealed under Policy Interpretation and Implementation:4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident, including injuries of an unknown source.The policy did not further address documentation of the notification about a resident's change in condition or status.The surveyor reviewed the facility provided policy titled Activities of Daily Living, Supporting dated April 2025 which did not address documentation of ADL or incontinence care.NJAC 8:39-27.1 (a) ;35.2