STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excel Care at Manalapan	104 Pension Road Manalapan, NJ 07726

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. COMPLAINT #2963689, 2978806 Based on interviews, review of medical records and other pertinent facility documentation on 5/28/26 and 5/29/26, it was determined that the facility failed to develop a comprehensive care plan to address the resident's discharge plans. This deficient practice was identified for 6 residents reviewed (Resident #1, Resident #2, Resident #4, Resident #5, Resident #6, and Resident #7) and was evidenced by the following:1.) A review of the admission Record revealed that Resident #1 was admitted to the facility with diagnoses that included but were not limited to: chronic kidney disease, hypotension, and mild cognitive impairment. A review of Resident #1's care plan did not reveal a focus related to the resident's preference and potential for future discharge. 2.) A review of the admission Record revealed that Resident #2 was admitted to the facility with diagnoses that included but were not limited to: congestive heart failure, type II diabetes, and dementia. A review of Resident #2's care plan did not reveal a focus related to the resident's preference and potential for future discharge. 3.) A review of the admission Record revealed that Resident #4 was admitted to the facility with diagnoses that included but were not limited to: type II diabetes, cognitive communication deficit, and post-traumatic stress disorder. A review of Resident #4's care plan did not reveal a focus related to the resident's preference and potential for future discharge. 4.) A review of the admission Record revealed that Resident #5 was admitted to the facility with diagnoses that included but were not limited to: epilepsy, type II diabetes, and hypertension. A review of Resident #5's care plan did not reveal a focus related to the resident's preference and potential for future discharge. 5.) A review of the admission Record revealed that Resident #6 was admitted to the facility with diagnoses that included but were not limited to: metabolic encephalopathy, secondary parkinsonism, and dementia. A review of Resident #6's care plan did not reveal a focus related to the resident's preference and potential for future discharge. 6.) A review of the admission Record revealed that Resident #7 was admitted to the facility with diagnoses that included but were not limited to: heart failure, atrial fibrillation, and hyperlipidemia. A review of Resident #7's care plan did not reveal a focus related to the resident's preference and potential for future discharge. An interview was conducted on 5/29/26 at 11:53 AM with the Director of Social Work (DSW) who stated that discharge planning for each resident was discussed during initial assessment of a new resident and during their quarterly assessments. During a follow-up interview with the DSW at 2:28 PM, she stated that the purpose of a care plan (CP) was to ensure that each resident's individual needs were explained to ensure involved members were aware of the level of care the resident required. She further stated that she had the ability to update resident's CP and that she did not include the residents' discharge plans as a focus area. An interview was conducted on 5/29/26 at 3 PM with the Director of Nursing (DON), who stated that a CP was a person-centered outline of the care that each resident required. She stated that discharge planning begins at the time of admission and that it was the responsibility of the DSW to ensure that discharge plans were included in the CP. When the surveyor asked the DON if she was aware that the DSW had not included discharge planning, the DON stated that she had come across one CP that did not include it but did not explain what action was taken when she saw it. The DON restated that discharge plans should be a part of each resident's CP. N.J.A.C. 8:39-27.1(a)

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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. COMPLAINT #2963689, 2978806 Based on interviews, record review, and review of facility documentation on 5/28/26 and 5/29/26 it was determined that the facility failed to a.) keep resident's medical information confidential and b.) follow facility policy titled Release of Information on maintaining the confidentiality of residents' information. The deficient practice was identified for one resident reviewed (Resident #6), and was evidenced by the following:A review of the admission Record revealed that Resident #6 was admitted to the facility with diagnoses that included but were not limited to: metabolic encephalopathy, secondary parkinsonism, and dementia. Further review revealed that the resident's address and that of their two contacts including phone numbers, were included in the resident's admission form. A review of Resident #6's care plan did not reveal a focus related to the resident's preference and potential for future discharge from the facility. A review of Resident #6's comprehensive Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated 4/21/26, revealed a Brief Interview of Mental Status (BIMS) of 5 out of 15, which indicated that the resident's cognition was severely impaired. A review of an undated facility document, titled: Investigation Summary and Conclusion provided to the surveyor by the Director of Nursing (DON), revealed that an investigation was initiated by the facility after they received an allegation that the, .facility improperly released.[Resident #6's] contact information to an outside facility. The document also confirmed that the facility contacted an outside third party facility and provided them with Resident 6's information, and asked the third party facility to reach out to Resident #6's family without getting permission from the resident's family first. An interview was conducted on 5/29/26 at 12:36 PM with the Licensed Nursing Home Administrator (LNHA) and the DON. The LNHA confirmed the above information. He stated that he identified and contacted an outside third part facility and provided them with Resident #6's information and that he sent a referral to the outside facility. The LNHA stated that he did this in preparation of Resident #6's discharge. The LNHA stated that he did not discuss this with Resident #6 due to their low cognition. He also stated that the resident did not have a Power of Attorney (POA) and that he did not reach out to the family regarding this facility. When asked who he obtained consent from to reach out to the outside facility on behalf of the resident he stated that he was under the impression that the family wanted options. When asked for documentation related to the family's knowledge that the outside facility was being contacted, none was provided. During a follow-up interview on 5/29/26 at 4:08 PM, with the LNHA, the DON, and the Regional Clinical Director (RCD), the LNHA reviewed the facility's Release of Information policy in the presence of the surveyor. When the surveyor asked if the LNHA followed this Policy Interpretation and Implementation, he stated that he had not completely followed the policy. After the survey, on 6/8/26 at 5:39 PM, the surveyor received an electronic message from the LNHA containing attachments. The LNHA indicated that the documents made up the referral packet that was forwarded to the outside facility for Resident #6. The document included Resident #6's Care Plan, Diagnosis Report (dated 3/27/26), admission Record (dated 3/27/26), PN with an effective date range of 2/1/26 to 3/15/26, and the Order Summary Report (dated 3/27/26). A review of the facility's Release of Information policy, revised November 2009, revealed that the facility would maintain resident confidentiality. The policy further revealed, . 3. All information contained in the resident's medical record is confidential and may only be released by the written consent of the resident or his/her legal representative . N.J.A.C. 8:39-4.1(a)18; 27.1(a)