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 _____	C 12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #s NJ175927 STANDARD SURVEY: 12/13/24 CENSUS: 104 SAMPLE SIZE: 21+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 2 of 21 residents reviewed for the accommodation of needs (Resident #8 and #11), and was evidenced by the following: On 12/2/24 at 11:00 AM, the surveyor observed the door to room [NJ Ex O] was closed. The surveyor heard someone from [NJ Ex O] calling out for assistance. The surveyor knocked and with	F 558	Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 2 of 21 residents reviewed for the accommodation of needs (Resident #8 and #11). 1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice:	1/13/25

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

Electronically Signed | 12/26/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 558	Continued From page 1 permission entered the room. The surveyor observed Resident #8 in their room seated in a wheelchair to the left of the bed. The surveyor observed that the resident's call bell (used to summon staff for assistance) was affixed to the right enabler, not within his/her reach. On 12/3/24 at 9:30 AM, the surveyor observed Resident #8 seated in a wheelchair to the left of the bed. The surveyor observed that the resident's call bell was affixed to the right enabler, not within his/her reach. On 12/4/24 at 8:40 AM, the surveyor observed Resident #8 seated in a wheelchair to the left of the bed. The surveyor observed that the resident's call bell was affixed to the right enabler, not within his/her reach. The surveyor reviewed the medical record for Resident #8. A review of Resident #8's Admission Record reflected that the Resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b) [redacted], and NJ Ex Order 26.4(b)(1). A review of Resident #8's quarterly Minimum Data Set, (MDS), an assessment tool dated NJ Ex Order 2 revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of "NJ out of 15" which indicated a NJ Ex Order 26.4(b)(1). The MDS further assessed that the resident required maximum assistance from staff for Activities of Daily Living (ADL) care. A review of Resident 8's Individualized Care Plan	F 558	"Resident #11 call bell was placed within reach immediately. The unit managers ensured the call light was within reach daily. Plan of care reviewed. "Resident #8 call bell was placed within reach immediately. Plan of care reviewed. "Education was conducted with assigned CNAs by Director of Nursing regarding the placement of call bell after care. "Education was completed with all nursing staff regarding the placement of the call bell. 2.Identification of residents who have the potential to be affected by the same deficient practice: "All residents have the potential to be affected by this deficient practice. 3.Systemic changes to ensure that the deficient practice does not recur: "Ongoing education will be provided to all nursing staff by the Director of Nursing regarding the placement of call bells after care. "Call bell policy reviewed, and education provided to all nursing staff by Director of Nursing. "The Director of Nursing or designee will check the placement of call bells daily at the beginning of each shift. 4.Monitoring corrective actions: "The Director of Nursing or designee will audit 5 call bells placement weekly x 3 months and then monthly x 3 months. "Results of the audit will be presented and reviewed during the quarterly Quality Assurance Performance Improvement	

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F 558	Continued From page 2 (CP) included a focus that indicated the resident had an NJ Ex Order 26.4(b)(1) deficit with an intervention that included but was not limited to Encouraging the resident to use the bell to call for assistance. On 12/2/24 at 11:19 AM, the surveyor and Certified Nursing Assistant (CNA #1) assigned to Resident #8's care that day, entered the resident's room and observed the resident seated in a wheelchair to the left of the bed and the call bell affixed to the right enabler, not within the resident's reach. CNA #1 acknowledged that she should have placed the call bell within the resident's reach. On 12/4/24 at 9:25 AM, the surveyor and CNA #2 assigned to Resident #8's care on 12/3/24 and 12/4/24 (7am-3:00 pm shift) entered the resident's room and observed the resident seated in a wheelchair to the left side of the bed with the call bell was affixed to the right enabler, not within the resident's reach. CNA #2 stated that he should have ensured the resident's call bell was within the resident's reach when he made his rounds each morning. On 12/2/24 at 11:38 AM, the surveyor observed Resident #11 in bed on a specialty mattress with the call bell on the floor under the resident's bed. The resident did not respond to the surveyor's greeting. The surveyor reviewed the medical record for Resident #11. A review of the Admission Record reflected Resident #11 was admitted to the facility with	F 558	(QAPI) meeting for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

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F 558	Continued From page 3 diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) A review of Resident #11's quarterly MDS dated NJ Ex Order 26.4 reflected Resident #11 had a BIMS score of NJ out of 15" which indicated a NJ Ex Order 26.4(b)(1) The MDS further assessed that Resident #11 was NJ Ex Order 26.4(b)(1) on staff for ADL care. A review of Resident #11's CP revealed a focus area that indicated the resident has an NJ Ex Ord related to a NJ Ex Order 26.4(b) with interventions that included encourage the resident to use the call bell for assistance. On 12/2/24 at 12:00 PM, the surveyor and CNA #3 entered resident #11's room. CNA #3 confirmed that the call bell should not be on the floor and acknowledged that all call bells should be placed within the resident's reach. A review of the facility's Call System policy and procedure indicated ...residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation ... On 12/4/24 at 1:33 PM, the surveyor discussed the above observations and concerns with the Administration. The U.S. FOIA (b) (6) confirmed that the call bells should be placed within the residents' reach.	F 558		

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F 558	Continued From page 4	F 558		
F 658 SS=D	NJAC 8:39- 31.8 (c)(9) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) blood pressure apparatus was utilized in accordance with the manufacturer's specifications, b.) an antibiotic treatment was administered as ordered by the physician, and in accordance with professional standards of practice. This deficient practice was observed during the medication pass observation of 1 of 5 nurses who administered to 1 of 6 residents (Resident #20) and identified for 1 of 1 resident investigated for abuse (Resident # 16). The evidence was as follows: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing,	F 658	Based on observation, interview, and record review, it was determined that the facility failed to ensure a.) blood pressure apparatus was utilized in accordance with the manufacturer's specifications, b.) an antibiotic treatment was administered as ordered by the physician, and in accordance with professional standards of practice. This deficient practice was observed during the medication pass observation of 1 of 5 nurses who administered to 1 of 6 residents (Resident #20) and identified for 1 of 1 resident investigated for abuse (Resident # 16). 1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: "Resident #20 [NJ Exec Order 26.4b1] was taken using the correct method as per manufacture□s specification. Resident #20 was not affected by the deficient practice. "[US FOIA (b)(6)] was educated immediately about proper use of	1/13/25

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F 658	Continued From page 5 and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." Reference: According to the manufacturer's specifications of the (brand name redacted) a blood pressure monitor machine, under measurement and procedure included the following: Wrap the cuff around upper left arm. Rubber tube should be on the inside of the extending arm. Ensure the cuff lies ½ to ¾ inches above the elbow. 2 fingers should fit between the arm and the cuff ... Refer F759 1.) On 12/4/24 at 9:52 AM, the surveyor observed Licensed Practical Nurse (LPN #1) who asked Resident #20, if she can take their NJ Exec Order 26.4b1 (BP). Resident #20 was NJ Ex Order 26.4(b)(1) and informed the surveyor and LPN #1 that they felt NJ Ex Order 2 At 9:53 AM, the surveyor observed LPN #1 place the NJ Exe NJ Exec on the resident's NJ Exec Order 26.4b1 , the NJ Exec Order 26.4b1 was on the outside	F 658	NJ Ex apparatus by unit manager. "Resident #16 was not affected by deficient practice. MD was notified of missed treatments. No new orders were given. "Education was completed by the Director of Nursing with US FOIA (b)(6) regarding the process to be followed when medications are not available. "Medication administration policy was reviewed and updated to reflect communication of missed medication with the physician. 2.Identification of residents who have the potential to be affected by the same deficient practice: "All residents have the potential to be affected by the deficient practice. 3.Systemic changes to ensure that the deficient practice does not recur: "Education was provided by the Director of Nursing to all nursing staff regarding proper placement of blood pressure cuff. "Education was provided by the Director of Nursing to all nursing staff regarding the process to be followed when medications are not available and documenting communication with physician. "Blood Pressure cuff placement competency added to orientation and annual training. 4.Monitoring of corrective actions: "The Director of Nursing or designee will audit the placement of blood pressure cuff by 2 nurses weekly for 1 month and then	

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F 658	Continued From page 6 of the NJ Exec Order 26.4b1 An error reading resulted. At that time, LPN #1 informed the surveyor that she used the same machine "around [redacted] something", that morning for the same resident and received a reading. At 9:56 AM, the surveyor observed LPN #1 retake the [redacted] on the same location, without an adjustment made to the [redacted], and the [redacted] LPN #1 received an error reading. At 9:57 AM, the surveyor observed LPN #1 place the [redacted] onto Resident #20's NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 on the outside of the [redacted] LPN #1 received an error reading. At 9:58 AM, the surveyor observed LPN #1 place the [redacted] on the resident's [redacted]. LPN #1 received an error reading. At 10:00 AM the U.S. FOIA (b) (6) [redacted]) entered the room and observed LPN #1 take Resident #20's [redacted] reading. At 10:01 AM, the surveyor and the U.S. FOIA (b) (6) observed LPN #1 place the [redacted] onto Resident #20's [redacted], the [redacted] was on the outside of the [redacted]. LPN #1 received an error reading. The surveyor asked LPN #1 if she had another machine in her cart. At that time, LPN #1 stated that she had only one machine which is the one she used with Resident #20. The [redacted] left the room to obtain another [redacted] machine. At 10:04 AM, the surveyor observed [redacted] walking with another [redacted] machine toward Resident #20's room. At that time, during an	F 658	monthly for 6 months. "The Director of Nursing or designee will audit 5 residents with treatment orders weekly for 1 month and then monthly for 6 months. "Results of the audit will be presented and reviewed during the quarterly Quality Assurance Performance Improvement (QAPI) meeting for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

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F 658	Continued From page 7	F 658		

interview with the surveyor, the [U.S. FOIA (b) (6)] stated that LPN #1 placed the [NJ Exec] too loose, the [NJ Exec] was at the wrong location, and that the rubber cord should have been on the inside of the extended arm. The [U.S. FOIA (b) (6)] stated that she would provide education to LPN #1, on how to properly use the [NJ Exec] monitor device.

On 12/4/24 at 10:49 AM, during an interview with the U.S. FOIA (b) (6), the surveyor discussed the concern with LPN #1's incorrect technique while using the [NJ Exec] device.

On 12/4/24 at 1:33 PM, in the presence of the survey team, U.S. FOIA (b) (6), the U.S. FOIA (b) (6), the U.S. FOIA (b) (6), the surveyor discussed the concerns regarding the incorrect technique used by LPN #1 while using the device for Resident #20 who had a physician ordered medication that had a NJ Exec Order 26.4b1, prior to administration.

No further information was provided.

2.) On 12/5/34 at 9:48 AM, the surveyor observed Resident #16 laying on their [NJ Exec Order 26] towards the [NJ Exec Order 26]. Resident #16 stated that sometime in November a physician ordered [NJ Ex Order 26.4(b)(1)] for their [NJ Ex Order 26] and there was a day or two, it was not administered.

On 12/5/24 at 10:29 AM during an interview with the surveyor, LPN #2 stated that the pharmacy delivered the medications sometime between the 7:00 AM to 3:00 PM shift and sometime between the 3:00 PM to 11:00 PM shift; if an item was missing from the orders, the nursing staff called the pharmacy, and requested for the item to be

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delivered. The facility also had a stat (immediate) order available which arrived withing 4 hours. LPN #2 also stated that the nursing staff communicated with the pharmacy through a tablet and the estimated time of arrival of the medication would be communicated back to the nurses from the pharmacy, through the same tablet.

The surveyor reviewed the medical record for Resident #16.

According to the Admission Record face sheet, an admission summary, reflected that Resident #16 was admitted to the facility with diagnoses that included: NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) [redacted]

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1).

Further review of the MDS reflected that the resident had a NJ Ex Order 26.4(b)(1) that was present upon admission with treatments that included NJ Ex Order 26.4(b)(1) medication.

A review of the individualized comprehensive care plan included a focus of Resident #16's [redacted] on the NJ Ex Order 26.4(b)(1) [redacted] which was present during admission. The interventions included administer treatment as ordered and monitor for effectiveness.

On 12/5/24 at 10:47 AM, the surveyor and the

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U.S. FOIA (b) (6)) reviewed the Order Audit Report together which reflected an order for NJ Ex Order 26.4(b)(1), to be applied to the NJ Ex Order 26.4(b)(1) once a day for NJ Ex Order 26.4(b)(1) for 10 days that was ordered by the physician on NJ Ex Order 26.4(b. The order was confirmed to be started on NJ Ex Order 26.. The order supply summary reflected that the medication was on hand (in stock) on NJ Ex Order 26.

The surveyor and the U.S. FOIA (b) (6 reviewed the electronic Medication Administration Record (eMAR) for NJ Ex Order 26.4(b)(1), which reflected that the doses on NJ Ex Order 26. and NJ Ex Order 26.4(b were not administered.

A review of the nurses' progress notes did not reflect that the physician, the U.S. FOIA (b) (6), or the U.S. FOIA (b) (6) were notified of the missed doses and a request for a later administration time was also not found.

A review of the packing slip reflected the pharmacy delivered the medication on NJ Ex Order 26.4(b)(a replenishment was sent on NJ Ex Order 26. and another replenishment was sent on NJ Ex Order 26.4(b)(.

A review of the NJ Ex Order 26.4(b surgical note documented by the physician on NJ Ex Order 26.4(b reflected that the resident's NJ Ex Order 26 was NJ Ex Order 2 and required NJ Ex Order 26.4(b)(1) therapy.

On 12/5/24 at 12:06 PM, the surveyor discussed with the U.S. FOIA (the concern regarding the two doses of NJ Ex Order 26.4(b)(1) that was not administered to Resident # 16, and the failure of the nursing staff to ensure the resident's physicians were informed

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F 658	Continued From page 10 of the two missed doses. On 12/9/24 at 10:53 AM, in the presence of the survey team, the U.S. FOIA (b) (6) stated that the facility policy did not require for the physician to be contacted unless two consecutive doses were missed which included NJ Ex Order 26.4b1. The U.S. FOIA acknowledged that the physician order was for the administration of NJ Ex Order 26.4(b)(1) for 10 days and only 8 doses were administered. The U.S. FOIA could not provide evidence that the physicians were aware of the missed doses. At that time, the U.S. FOIA agreed that it was not the standard of practice for a physician not to be informed when the course of therapy ordered was not followed. A review of the provided facility policy, Medication Administration, dated 5/1/24, included the following under documentation: if a dose of regularly scheduled medication is withheld refused or given at other than the scheduled time... The administering person will document in the MAR an explanatory note is entered in the progress note. If two consecutive doses of a vital medication are withheld or refused the physician is notified. NJAC 8:39-11.2(b), 27.1(a)(b)	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint NJ#175927	F 677	Based on observation, interview, and	1/13/25

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

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F 677	Continued From page 11 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure that NJ Ex Order 26.4(b)(1) care was provided to a NJ Ex Order 26.4(b)(1) resident for 1 of 4 residents reviewed for NJ Ex Order 26.4(b)(1) care (Resident #71) on 1 of 2 nursing units, NJ Ex Ord floor unit. This deficient practice was evidenced by the following: On 12/2/24 at 11:00 AM, the surveyor observed Resident #71 in the bathroom seated in a wheelchair. The surveyor observed the resident NJ Ex Order 26.4(b)(1) . The surveyor observed NJ Ex Order 26.4(b)(1) were in place, both NJ Ex Order 26.4(b)(1) . At that time, the US FOIA (b)(6) who was in Resident #71's room, stated that she was not assigned to provide direct care and left to summon the Certified Nursing Assistant (CNA) assigned to Resident #71's care. On 12/2/24 at 11:13 AM, the CNA entered Resident 71's room. The CNA observed the resident's NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(. The CNA stated that she had 12 Residents on her assignment and therefore had not provided any care for Resident 71 that morning. The CNA confirmed that NJ Ex Order 26.4(b)(1) were unacceptable. The surveyor reviewed the medical record for Resident #71. A review of the Admission Record reflected the resident was admitted to the facility with diagnoses that included NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)	F 677	review of pertinent facility documents, it was determined that the facility failed to ensure that NJ Ex Order 26.4b1 was provided to a NJ Ex Order 26.4b1 resident for 1 of 4 residents reviewed for NJ Exec Order 26.4b1 care (Resident #71) on 1 of 2 nursing units, NJ Ex O -floor unit. 1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: "Resident #71 was assisted with NJ Ex Order 26.4(b)(1) care immediately. NJ Ex Ord was assessed, no changes in NJ Ex Order 26.4(b)(1) noted. "Education was provided by the Director of Nursing to U.S. FOIA (b) (6) regarding timely NJ Ex Order 26.4(b)(1) care. "Plan of care updated for all residents who prefer to use . 2.Identification of residents who have the potential to be affected by the same deficient practice: "All incontinent and dependent residents have the potential to be affected by the deficient practice. 3.Systemic changes to ensure that the deficient practice does not recur: "Education provided by Director of Nursing to all nursing staff regarding timely incontinent care as per residents needs. "Residents requesting for two briefs will be evaluated quarterly and annually and preference will be included in the plan of care. "Incontinence rounds added/included in	

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 _____	C 12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12 [redacted] and [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] reflected Resident #71 had a Brief Interview for Mental Status (BIMS) score of "[redacted] out of 15" which indicated a [redacted]. Further review indicated Resident #71 required [redacted] and was [redacted]. A review of the resident's Individual Care Plan (CP) revealed no care plans that addressed Resident #71's [redacted] care. A review of the facility's Incontinent Care policy dated 5/1/24 included ...the purpose is to provide consistent, compassionate, and effective care for residents with incontinence, ensuring dignity, comfort, and prevention of complications such as skin breakdown or infections ...develop and document a care plan tailored to each resident's needs ...staff must check and change incontinence products as needed, following the resident's care plan and at least every 2-4 hours or when soiled ... On 12/4/24 at 1:33 PM, the survey team met with the [redacted] to discuss the above observations and concerns. The [redacted] acknowledged that two [redacted] briefs should not be used unless requested by the resident due to the [redacted]. The [redacted] confirmed that the CP for [redacted] care and the resident preference for the use of [redacted] had not been initiated until 12/2/24 after the surveyor's inquiry. NJAC 8:39-27.1(a), 27.2(h)	F 677	the unit manager□s daily rounding to ensure incontinence care is provided as per the residents□ needs. 4.Monitoring of corrective actions: "The Director of Nursing or designee will audit 5 incontinent residents weekly for month and then monthly for 6 months to ensure incontinent care is provided in a timely manner. "The Director of Nursing will audit all incontinent residents for preference of two briefs weekly for 1 months and then monthly for 6 months to ensure resident□s preference is reflected in the plan of care. "Results of the audit will be presented and reviewed during the quarterly Quality Assurance Performance Improvement (QAPI) meeting for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

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F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication pass on 12/4/24, the surveyor observed five (5) nurses administer medications to six (6) residents. There were 26 opportunities and two (2) errors observed which calculated to a medication administration error rate of 7.6 %. The deficient practice was identified for 2 of 5 nurses for 2 of 6 residents, (Resident #97 and #20) as evidenced by the following: 1. On 12/4/24 at 08:46AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare medications for Resident #97. The medications included a physician's order for NJ Ex Order 26.4(b)(1) [redacted], 1 tablet by mouth every 12 hours for NJ Ex Order 26.4(b)(1) with an order date of NJ Ex Order 26.4(b) [redacted]. At 8:51 AM, the surveyor observed LPN #1 pour one (1) tablet of NJ Ex Order 26.4(b)(1) into a medication cup for administration to Resident #97. LPN #1 informed the surveyor that the container of NJ Ex Order 26.4(b)(1) was a NJ Ex Order 26 [redacted] At 8:54 AM, the LPN #1 confirmed with the	F 759	Based on observation, interviews, and record review, it was determined that the facility failed to ensure that all medications were administered without error of 5% or more. During the medication pass on 12/4/24, the surveyor observed five (5) nurses administer medications to six (6) residents. There were 26 opportunities, and two (2) errors observed which calculated to a medication administration error rate of 7.6 %. The deficient practice was identified for 2 of 5 nurses for 2 of 6 residents, (Resident #97 and #20) 1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: "LPN #1 was educated by the Director of Nursing about verification of correct medication during medication administration and process to follow if a medication is not available. "A medication administration observation was completed on LPN #1 by the Director of Nursing. "Resident #97 did not receive the wrong medication and was NJ Ex Order 26.4(b)(1) by the deficient practice. "LPN #2 was educated by the Director of Nursing about proper medication	1/13/25

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	315103	A. BUILDING _____ B. WING _____	C 12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

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F 759	Continued From page 14 surveyor that she was ready to administer the resident's medication and walked toward the resident's room threshold. At 8:55 AM, the surveyor stopped the medication pass observation at the resident's room threshold and asked LPN #1 to walk back to the med cart parked at the hallway. At 8:56 AM, the surveyor and the LPN #1 reviewed the electronic Medication Administration Record (eMAR) against the house stock bottle from which the NJ Ex Order 26.4(b)(1) was poured from. At 8:58 AM, LPN #1 confirmed and acknowledged that she had poured the wrong drug and recognized the physician order was for NJ Ex Order 26.4(b)(1) as opposed to the poured medication of NJ Ex Order 26.4(b)(1) 2. On 12/4/24 at 9:37 AM, the surveyor observed LPN #2 prepare medications for Resident #20. The medications included a physician's order for NJ Ex Order 26.4(b)(1), 1 tablet by mouth one time a day for NJ Ex Order 26.4(b)(1) hold for NJ Ex Order 26.4(b)(1). At 9:40 AM, LPN #2 took out a small notebook that reflected the resident's room number and NJ Exec Order 26.4b1 LPN #2 entered the NJ Exec values from the notebook into the eMAR. At 9:48 AM, LPN #2 confirmed with the surveyor that she was ready to administer the resident's medication and walked toward the resident's room threshold.	F 759	administration procedure when administering NJ Ex Order 26.4(b)(1) medication with a NJ Ex Order 26.4(b)(1). LPN #2 was educated to complete blood pressure right before administering medication. "The LPN #2 completed NJ Exec Order 26.4b1 right after and administered medication as per protocol. Resident #20 was not affected by the deficient practice. "A medication administration observation was completed on LPN #2 by the Director of Nursing. 2.Identification of residents who have the potential to be affected by the same deficient practice: "All residents have the potential to be affected by the deficient practice. 3.Systemic changes to ensure that the deficient practice does not recur: "Education completed, and the medication administration policy and procedure revised and updated on 12/20/24, with all nurses. "The pharmacy consultant will continue with medication administration observations and education monthly to ensure competency of all nurses. 4.Monitoring of corrective actions: "The Director of Nursing or designee will complete medication observation on 3 nurses monthly for 6 months to ensure competency of nurses with an emphasis on medication verification and blood pressure completion right before administering hypertensive medications with BP parameter.	

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 _____	C 12/13/2024

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

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F 759	Continued From page 15 At that time, the surveyor stopped the medication pass observation at the resident's room threshold and asked LPN #1 to walk back to the med cart parked at the hallway. At 9:50 AM, during an interview with the surveyor, LPN #2 stated that she had taken Resident #20's NJ Exec Order 26.4b1 " that morning. At that time, LPN #2 acknowledged that the NJ Ex Order 26.4b1 should have been taken immediately before the administration of the NJ Ex Order 26.4(b in accordance with the physician's order. On 12/4/24 at 10:49 AM, during an interview with the U.S. FOIA (b) (6), the surveyor discussed the concerns regarding the medication pass observation. On 12/4/24 at 1:33 PM, in the presence of the survey team, U.S. FOIA (b) (6), the U.S. FOIA (b) (6), the U.S. FOIA (b) (6), the surveyor discussed the concerns regarding the incorrect medication poured for administration for Resident #97 and the concern regarding the NJ Ex Order 26.4b1 that was not taken prior to administration in accordance with the physicians' order for Resident #20. A review of the provided facility policy, Medication Administration, dated 5/1/24, included: Medications are administered as prescribed in accordance with good nursing principles and practice. NJAC 8:39-11.2(b), 29.2(d)	F 759	"Results of the audit will be presented and reviewed during the quarterly Quality Assurance Performance Improvement (QAPI) meeting for 6 months, and additional corrective action will be implemented if deficiencies are identified.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315103 Y1	A. Building B. Wing Y2	2/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0558	Correction	ID Prefix F0658	Correction	ID Prefix F0677	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	01/13/2025	LSC	01/13/2025	LSC	01/13/2025
ID Prefix F0759	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(f)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/13/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061614		2/3/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/13/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 12/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**12/13/2024**

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EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE** **WAYNE, NJ 07470**

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 12/11/24, 12/12/24 and 12/13/24, Excel Care at Wayne was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Excel Care At Wayne is a 2- story building with a partial basement that was built in 1969. It is composed of Type II protected construction. The facility is divided into 9- smoke zones as per the Maintenance Director. The facility has a 150 KW external diesel emergency power generator.	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	K 293		12/23/24

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

Electronically Signed | 12/27/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**12/13/2024**

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K 293	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations on 12/13/24, it was determined the facility failed to provide a "NO Exit" sign at a stairway door that was neither an exit nor a way of exit access and that was located or arranged so that it was likely to be mistaken for an exit in accordance with NFPA 101: 2012 Edition, Section 19.2.10 and 7.10.8.3.1. This deficient practice had the potential to affect all 1st floor residents and was evidenced by the following: An observation at 11:55 AM revealed the stairwell door by room 118 was identified as stairs by a sign and had an exit sign suspended from the corridor ceiling approximately 8-inches to the left of the opening edge of the door. The exit sign was approximately 7-inches off the corridor wall and had chevron arrows pointing to both the right and left. The appearance of the stairwell door and the close proximity to the exit sign made the door likely to be mistaken for an exit and would require a sign on the door that reads "NO Exit". The stairwell serves as an exit from the second floor to the first floor and is not an exit from the first floor. In an interview at 1:12 PM the U.S. FOIA (b) (6) was informed of the deficient practice. NJAC 8:39-31.1(c), 31.2(e)	K 293	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: No Exit sign was placed on stairwell door by room 118 on 12/23/24. 2.Identification of residents who have the potential to be affected by the same deficient practice: All 1st floor residents had the potential to be affected. 3.Systemic changes to ensure that deficient practice does not recur: Maintenance has been in service on Exit signage. Maintenance/designee will conduct monthly walking audits of all exit doors outside for compliance and tracking. Findings of audits will be submitted to the Administrator for review. 4.Monitoring corrective actions: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, will review the audit on a Quarterly basis x 12 months to ensure compliance.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier	K 321		12/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 321	Continued From page 2 having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/12/24 in the presence of the U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6) it was determined that the facility failed to ensure that hazardous areas were protected in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 7.2.1.8, 9.7 and 8.4. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 321	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: A self-closer was added to kitchen door and laundry storage room on 12/14/24. A Latch added to dietary disposable storage room and medical records room on 12/14/24. 2.Identification of residents who have the	

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	315103	A. BUILDING **01** B. WING _____	**12/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 1. An observation at 11:13 AM revealed the door to the Kitchen was on a hold open device. When released, the kitchen door did not close all the way into its frame. The door stopped at the edge of the door frame. The test was repeated 2 times with the same results. In an interview at the time, the U.S. FOIA (b) confirmed the observation. 2. An observation at 11:32 AM revealed the storage room by laundry had combustible boxes stored and the door was not equipped with a self-closing or automatic closing device. 3. An observation at 11:36 revealed the dietary disposable storage room door did not positive latch when opened to 90 degrees and released. The test was repeated 3 times by the U.S. FOIA (b) with the same results. 4. An observation of the basement medical records room revealed storage of combustible paper records with boxes stacked throughout the room. The door to the room was not equipped with a self-closing or automatic closing device. In interviews at the times, the U.S. FOIA (b) confirmed the observations. The U.S. FOIA (b) (6) and U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 12/13/24 at 11:50 AM N.J.A.C 8:39-31.2(e)	K 321	potential to be affected by the same deficient practice: All residents had the potential to be affected by the deficient practice. 3. Systemic changes to ensure that deficient practice does not recur: Maintenance has been serviced on protecting hazardous areas enclosures. The Maintenance Director/designee will conduct monthly walking audits off all doors within hazardous areas for compliance and tracking. Findings of audits will be submitted to the Administrator for review. 4.Monitoring corrective actions: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review audits on a Quarterly basis x 12 months to ensure compliance.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101	K 324		1/6/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**12/13/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE** **WAYNE, NJ 07470**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 4 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/2024 in the presence of the U.S. FOIA (b) (6) [redacted], it was a determined that the facility failed to perform monthly inspections of the range-hood fire suppression system wet chemical cylinder in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all residents and was evidenced by the following:	K 324	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: The Maintenance director reached the vendor which confirmed that the inspection was completed, however they do not keep previous tags 2.Identification of residents who have the potential to be affected by the same deficient practice:	

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K 324	Continued From page 5 An observation at 11:15 AM of the kitchen range-hood fire suppression system wet chemical inspection tag, revealed the semi-annual inspection was performed on 12/2/2024 and the tag was new. The facility did not have the monthly inspection documentation from the previous report indicating the monthly owners inspection had been performed for the previous 6 months of: November, October, September, August, July, and June of 2024. No further documentation was provided. In an interview at the time, the U.S. FOIA (b) confirmed the observation. The U.S. FOIA (b) (6) and U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 12/13/24 at 11:50 AM. NJAC 8:39-31.2(e) NFPA 17 A, 96	K 324	All residents had the potential to be affected by the deficient practice. 3.Systemic changes to ensure that deficient practice does not recur: The U.S. FOIA (b) (6) was in serviced to conduct monthly audits of kitchen hood suppression inspections and automatic sprinkler separations. Maintenance/designee will complete audit inspections and sign off tags of suppression systems the first week of every month. Monthly audit logs will be submitted to the Administrator for review and kept in the Maintenance office. 4.Monitoring corrective actions: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review the monthly audit on a Quarterly basis x 12 months to ensure compliance.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked	K 353		1/31/25

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	315103	A. BUILDING **01** B. WING _____	**12/13/2024**

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K 353	Continued From page 6 _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/12/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined the facility failed to ensure fire system sprinkler heads were maintained and ceiling smoke barriers were maintained in accordance with NFPA 101: 2012 edition, Sections 9.7.5, 19.3.5.1, and NFPA 25: 2011 edition. These deficient practices had the potential to affect all residents and were evidenced by the following: Observations during a tour of the facility between 10:47 AM and 2:12 PM revealed the following: 1. The kitchen office sprinkler head escutcheon plate was missing. 2. Room 122 bathroom had the drop ceiling tee missing along the 4-foot edge of a 2-foot by 4-foot ceiling tile causing the tile to sag down, leaving a half inch open space the length of the ceiling tile next to the sprinkler head. 3. Room 126 bathroom had the drop ceiling tile off the grid tee along the 4-foot edge of a 2-foot by 4-foot ceiling tile causing the tile to sag down leaving a 2-inch open space along the 4-foot length of the ceiling tile next to the sprinkler head.	K 353	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: The Maintenance Director received proposal from vendor for kitchen office sprinkler head (X1) and second floor dining room (X2) for escutcheons. See attached evidence. The drop ceiling was replaced in the bathroom of rooms 122 and 126 on 12/14/24. The drop ceiling was replaced in the storage closet by room 212 on 12/14/24. 2. Identification of residents who have the potential to be affected by the same deficient practice: All residents had the potential to be affected by the Sprinkler Systems. 3.Systemic changes to ensure that deficient practice does not recur: The U.S. FOIA (b) (6) was in-serviced on Sprinkler System Maintenance and Testing. The Maintenance director/designee will conduct monthly walking audits of all sprinkler systems on all floors.	

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K 353	Continued From page 7 4. The storage closet by room 212 had a space along the side of the sprinkler escutcheon cap penetrating through the drop ceiling. 5. The second floor dining room had 2 of the 12 sprinkler heads missing the escutcheon plates. In interviews at the times, the U.S. FOIA (b) confirmed the observations. The U.S. FOIA (b) (6) and U.S. FOIA (b) were informed of the deficient practices at the Life Safety Code survey exit conference on 12/13/24 at 11:50 AM. N.J.A.C 8:39-31.2(e) NFPA 13, 25	K 353	4.Monitoring corrective actions: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review the monthly audit on a Quarterly basis x 12 months to ensure compliance.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 12/12/24 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) it was determined that the facility failed to ensure that the Class K portable fire extinguishers was provided with an instructional placard conspicuously placed near the extinguisher in accordance with NFPA 101: 2012 Edition, Sections 9.7.4, NFPA 10: 2010 Edition, Sections 5.5.5.3, A 5.5.5.3 and NFPA 96: 2011 Edition,	K 355	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: The K rated fire extinguisher was moved to the proper location next to instruction placard. It is still in the kitchen in an accessible location. See attached evidence. 2. Identification of residents who have the	12/25/24

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K 355	Continued From page 8 Sections 10.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:26 AM revealed the Class K fire extinguisher in the kitchen was not provided with an instruction placard that stated the fire protection system shall be actuated prior to using the portable fire extinguisher. In an interview at the time, the U.S. FOIA (b) and U.S. FOIA (b) (6) confirmed the observation. The U.S. FOIA (b) (6) and U.S. FOIA (b) were informed on the deficient practice at the Life Safety Code exit conference on 12/13/24 at 11:50 AM. N.J.A.C 8:39-31:2(e) NFPA 10, 96	K 355	potential to be affected by the same deficient practice: All residents had the potential to be affected by the deficient practice. 3.Systemic changes to ensure that deficient practice does not recur: The U.S. FOIA (b) (6) was in-serviced on keeping all monthly placards of portable fire extinguishers. The maintenance Director/designee will maintain a log on all placards monthly. Findings will be submitted to the Administrator for review. Additionally, the maintenance Director will keep onsite placards for a period of at least one year prior to the current year. 4.Monitoring corrective actions: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review the monthly audits on a Quarterly basis x 12 months to ensure compliance.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521		1/13/25

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K 521	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/24 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined the facility failed to ensure residents bathroom exhaust fans were maintained in operational condition in accordance with NFPA 101:2012 edition, Sections 19.5.2.1, 9.2 and NFPA 90A. This deficient practice had the potential to affect 50 residents and was evidenced by the following: Observations during a facility tour between 10:47 AM and 1:55 PM revealed 3 of 7 resident room bathrooms observed did not have windows and the exhaust fans did not operate. The non-operational exhaust fans were located in rooms: 122, 126 and 218. In an interview at the time, the U.S. FOIA (b) [redacted] confirmed the observations and stated that if the main exhaust fan for the section is down, all the bathrooms served by that unit will not work so the north unit is down. The U.S. FOIA (b) (6) and U.S. FOIA (b) [redacted] were informed of the deficient practice at the Life Safety Code survey exit conference on 12/13/24 at 11:50 AM. NJAC 8:39-31.2 (e) NFPA 90A	K 521	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice: The maintenance Director has repaired exhaust fans in rooms 122, 126 and 218. See evidence attached. 2. Identification of residents who have the potential to be affected by the same deficient practice: All residents had the potential to be affected by the deficient practice. 3.Systemic changes to ensure that deficient practice does not recur: The U.S. FOIA (b) (6) was educated in maintaining heating, ventilation, and air conditioning in all patient rooms. The Maintenance Director/ designee will audit HVAC systems throughout the facility, in patient rooms every six months. Findings will be submitted to the Administrator for review. 4.Monitoring corrective actions: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review the bi-yearly audit on a Quarterly basis x 1 year to ensure compliance.	
K 918 SS=F	Electrical Systems - Essential Electric Syste	K 918		1/21/25

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K 918	Continued From page 10 CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/24	K 918	1.Corrective Actions Accomplished for	

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K 918	Continued From page 11 and 12/13/24 in the presence of the U.S. FOIA [redacted] it was determined the facility failed to ensure the Essential Electrical System (EES) was provided with a remote manual stop station for the generator set in accordance with NFPA 99: 2012 Edition, Section 6 and NFPA 110: 2010 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 12/12/24 at 2:30 PM revealed the facility generator was located outside the building. Further observation revealed that there was no remote manual stop station to prevent inadvertent or unintentional operation. In an interview on 12/13/24 at 11:14 AM, the U.S. FOIA (b) [redacted] stated that the facility was aware of the requirement to provide a remote manual stop station and he cannot find one at the time and the U.S. FOIA (b) (6) does not know of a remote generator shut off. The U.S. FOIA (b) (6) and U.S. FOIA (b) [redacted] were informed of the deficient practice at the Life Safety Code Exit conference on 12/13/24 at 11:50 AM. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	residents found to have been affected by the deficient practice: Powerhouse Generators will be installing the remote manual stop on 1/21/25, due to the recent cold weather and freezing of the ground. Appointment confirmation attached. 2.Identification of residents who have the potential to be affected by the same deficient practice: All residents had the potential to be affected by the deficient practice. 3.Systemic changes to ensure that deficient practice does not recur The U.S. FOIA (b) (6) was educated to maintain remote manual stop and electrical systems. The Maintenance Director/Designee will test remote manual stop during weekly generator testing. Findings will be submitted to the Administrator for review. 4.Monitoring corrective actions Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review the monthly audits on a Quarterly basis x 12 months to ensure compliance.	
K 921 SS=F	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements	K 921		12/24/24

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K 921	Continued From page 12 The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 12/11/24, 12/12/24 and 12/13/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) it was determined that the facility failed to provide policies and procedures for Patient Care Related Electrical Equipment (PCREE), and conduct maintenance of electrical equipment and maintain a record log of all required testing, test results and repairs in	K 921	1.Corrective Actions Accomplished for residents found to have been affected by the deficient practice The VPPO on 12/24/24 updated Electrical Equipment Testing and Maintenance policy and procedure dated 5/1/24, to include Patient Care Related Electrical Equipment (PCREE)	

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K 921	Continued From page 13 accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6 and 10.5.8. The deficient practice had the potential to affect all residents and was evidenced by the following: A documentation review on 12/11/24 between 9:30 AM and 2:00 PM revealed there was no documentation of PCREE testing, inspection and maintenance provided. In an interview on 12/11/24 at 2:00 PM, the surveyor asked the Maintenance coordinator and Administrator to provide any PCREE documents for the next day. In an interview on 12/13/24 at 11:23 AM, the U.S. FOIA (b) and U.S. FOIA (b) (6) stated that the U.S. FOIA (b) (6) inspects their electrical equipment and puts a sticker on it. There were no policy and procedures for a comprehensive maintenance, testing and inspection program or inspection reports for patient care related electrical equipment for the facility at this time. The U.S. FOIA (b) (6) and U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 12/13/24 at 11:50 AM. NJAC 8:39-31.2(e) NFPA 99	K 921	2.Identification of residents who have the potential to be affected by the same deficient practice: All residents had the potential to be affected by the deficient practice. 3.Systemic changes to ensure that deficient practice does not recur: The U.S. FOIA (b) (6) was educated on the policy for the maintenance of electrical equipment, and to tag and log all required testing and results and repairs. The Maintenance Director/designee will conduct routine monthly audits of all electrical equipment per manufacturer specifications for results and repairs. Maintenance will tag all inspected equipment. Findings will be submitted to the Administrator for review 4.Monitoring corrective action: Corrective actions will be evaluated for effectiveness, and the plan of corrections will be integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee will review the monthly audit on a Quarterly basis x 12 months to ensure compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315103 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	12/23/2024	LSC K0321	12/14/2024	LSC K0324	01/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	01/31/2025	LSC K0355	12/25/2024	LSC K0521	01/13/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0918	01/21/2025	LSC K0921	12/24/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
12/13/2024	☐ YES ☐ NO