

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		
(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) COMPLETE DATE
M 000	Initial Comments Type of Survey: Expansion and Renovation (the facility is requesting an additional 100 slots/session) Census: 0 Sample Size: 0 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000		
M 575	8:43F-11.2(c) Rehabilitation Services If the facility provides physical therapy on-site, physical therapy equipment available to the participants shall include at least parallel bars, stairs, mats, and padded tables. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide the minimum Physical Therapy equipment required by regulation for providing these services on-site as evidenced by the following: On 1/28/25 at 10:35 a.m., a tour of the facility was	M 575		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/26/25

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		
(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) COMPLETE DATE
M 575	Continued From page 1 performed. At 10:50 a.m., an inspection of the Physical Therapy/Occupational Therapy room was performed. The surveyor observed inside the room four (4) therapy tables, one (1) set of stairs, one (1) evacuation diagram and other various exercise equipment. The surveyor observed no evidence of parallel bars. The facility failed to meet the requirements of this regulation by not providing the parallel bars. At 10:55 a.m., during interview with the facility Owner, the owner confirmed the finding(s). At 2:45 p.m., during the exit, the facility Owner and the Administrator were informed of the deficient practice. N.J.A.C. 8:43 F-11.2 (c)	M 575			
M 597	8:43F-14.1(a) Physical Plan Requirements Construction standards for freestanding facilities for new buildings and alterations, renovations, and additions to existing buildings for freestanding adult health services facilities shall comply with N.J.A.C. 5:23-3.2 of the New Jersey Uniform Construction Code; the New Jersey Uniform Fire Code, N.J.A.C. 5:70; and with N.J.A.C. 5:23-7, the Barrier-Free Subcode of the New Jersey Uniform Construction Code.	M 597			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726			
(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) COMPLETE DATE
M 597	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to create a stable walking surface from an emergency egress exit to a public place of refuge as evidenced by the following: On 1/28/25, during the tour of the facility which started at 10:35 a.m., the surveyor inspected one (1) of six (6) emergency egress doors, which only had a concrete slab which measured 6 feet 7 inches by 7 feet by 1 inch, surrounded by grass and uneven ground. At 2:45 p.m., during the exit conference, the facility Owner and the Administrator were informed of the deficient practice. 8:43F-14.1 (a)	M 597			
M 685	8:43F-14.17(d) Physical Plant Requirements The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and evacuation as part of their initial orientation and at least annually thereafter. This REQUIREMENT is not met as evidenced by:	M 685			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		
(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) COMPLETE DATE
M 685	Continued From page 3 Based on observation and interview it was determined that the facility failed to include all required information on the emergency evacuation diagrams that were posted. This deficient practice was evidenced by the following: On 1/28/2025 at 10:35 a.m. during the tour of the building, in the presence of the facility Owner, the surveyor observed all the emergency evacuation diagrams. All evacuation diagrams failed to include the locations of the fire alarm pull stations and fire extinguishers. The emergency evacuation diagrams were posted in various locations throughout the facility. At 2:45 p.m., the facility Owner and administrator were notified of the deficient practice. 8:43F-14.7 (d)	M 685		
M 691	8:43F-14.17(h) Physical Plant Requirements Fire extinguishers shall be examined annually and maintained in accordance with manufacturers' and National Fire Protection Association (NFPA) requirements. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observations, interview and review of	M 691		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		
(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) COMPLETE DATE
M 691	Continued From page 4 facility documentation, it was determined that the facility failed to inspect three (3) of the fire extinguishers annually as required, as evidenced by the following: On 1/28/2025 at 10:35 a.m., a fire tour of the facility was performed. At 10:40 a.m., the surveyor observed two (2) ABC extinguishers in the corridor failed to have the six (6) year maintenance. At 10:44 a.m., the surveyor also observed an ABC fire extinguisher in the boiler room failed to maintain the six (6) year maintenance. At 10:48 a.m., the facility Owner confirmed the findings. At 2:45 p.m., during the exit conference, the facility Owner and the Administrator were notified of the deficient practice. 8:43F-14.17 (h)	M 691			
M 791	8:43F-16.2(m) Infection Control, Santation, Housekeeping Equipment and supplies used for sterilization, disinfection, and decontamination purposes shall be maintained according to manufacturers' specifications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of records it was determined that the facility failed to follow manufacturers' guidelines for cleaning and disinfecting of the facility's glucometer as evidenced by the following:	M 791			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		
(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) COMPLETE DATE
M 791	Continued From page 5 On 1/28/25 the surveyor conducted a renovation and expansion survey at the facility which the facility applied for an additional 100 slots/session. At 11:08 a.m., the surveyor toured the Nursing Office and interviewed the Director of Nursing (DON) regarding the clinical equipment used by the program. The surveyor requested the facility's glucometer, and the DON provided the surveyor with the "McKesson True Metrix PRO" glucometer which was intended for multi-use. Additionally, the surveyor requested the disinfectant that the facility used to clean/disinfect the multi-use glucometer. The DON provided the surveyor a container of "NJ Ex Order 26.4b1" Wipes. At 12:09 p.m. the DON confirmed with the surveyor that she used the NJ Ex Order 26.4b1 wipes to clean/disinfect the glucometer. At 1:16 p.m., the Business Administrator (BA) provided the surveyor with a receipt from a convenience store that reflected the purchase of two containers of Super Sani-Cloth Wipes, which was dated on 1/28/25 at 1:04 p.m. At 12:27 p.m., the surveyor reviewed the manual for the glucometer and observed that the manual revealed that the proper disinfectant for the glucometer was Super Sani-Cloth Wipes. At 2:54 p.m., during interview with the BA and Administrator, both confirmed that the facility did not use the manufacturer's approved disinfectant for the glucometer at the facility prior to the survey date, 1/28/25. The surveyor reviewed the undated facility policy titled, "Glucometer quality control" which indicated, "... Procedure: A. All Glucometer.	M 791		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13001	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER GOLDEN YEARS CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		
(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) COMPLETE DATE	
M 791	Continued From page 6 Follow manufacturer instruction on glucometer care and use..."	M 791			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 13001	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 3/4/2025	Y3
NAME OF FACILITY GOLDEN YEARS CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 108 WOODWARD ROAD MANALAPAN, NJ 07726		

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 M0575	Correction	ID Prefix M0597	Correction	ID Prefix M0685	Correction
Reg. # 8:43F-11.2(c)	Completed	Reg. # 8:43F-14.1(a)	Completed	Reg. # 8:43F-14.17(d)	Completed
LSC	03/04/2025	LSC	03/04/2025	LSC	03/04/2025
ID Prefix M0691	Correction	ID Prefix M0791	Correction	ID Prefix	Correction
Reg. # 8:43F-14.17(h)	Completed	Reg. # 8:43F-16.2(m)	Completed	Reg. #	Completed
LSC	03/04/2025	LSC	03/04/2025	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 1/28/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
--	--