

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 R 09/03/2025
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: Monitoring/Follow-up to the 8/14/2024 audit survey conducted by the Office of the Inspector General. Census: Two Sessions: Morning: 156 and Afternoon: 191 Sample Size: 5 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 653	8:43F-14.11(a)(1-3)(i-ii),(4-7) Physical Plant Requirements (a) The construction, equipment, and installation of food service facilities shall meet the requirements of the functional program. Services may consist of an on-site conventional food preparation system, a convenience food service system, a catering service or an appropriate combination thereof. The following facilities shall be provided to implement the food service selected: 1. A control station for receiving food supplies; 2. Storage facilities for food supply, including cold storage items;	M 653		

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

TITLE

(X6) DATE

10/09/25

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M 653	Continued From page 1 3. Food preparation facilities as follows: i. A conventional food preparation system with space and equipment for preparing, cooking and baking; and ii. A convenience food system, such as frozen prepared meals, bulk packaged entrees, individually packaged portions, and contractual commissary services with space and equipment for thawing, portioning, cooking, and/or baking; 4. Handwashing facility(ies), located in the food preparation area; 5. Warewashing space, which shall be located in the kitchen or an alcove separate from the food preparation and serving area; 6. Waste storage facility(ies), which shall be located in a separate room easily accessible to the outside for direct waste pickup or disposal; and 7. Office(s) or desk space(s) for dietitian(s) or the food service manager.	M 653		

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M 653	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and observation, it was determined that the facility failed to properly store perishable food items, one gallon of milk. This deficient practice was evidenced by the following: 1. On 8/14/24 the Office of the Inspector General (OIG) conducted a survey at the facility which revealed there was milk observed sitting on the counter and not in the refrigerator. 2. On 9/3/25 at 12:30 p.m., the surveyor toured the facility with the facility owner and observed a facility staff member removed milk from the refrigerator, poured the milk into a cup and left the milk container on the counter. The facility staff member walked away from the counter where she left the milk to assist another participant. The facility owner then removed the milk from the counter and placed it in the refrigerator. At 3:15 p.m., the surveyor interviewed the Administrator and informed him that there was milk left on the counter after being used by the facility staff. The Administrator stated that the staff were aware that milk should be returned to the refrigerator after use.	M 653			
M 701	8:43F-15.3(a)(1) Medical Records (a) The participant's complete medical record shall include, but not be limited to, the following: 1. Participant identification data, including name, date of admission, address, date	M 701			

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M 701	Continued From page 3 of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain current participant emergency contact information for 4 of 5 participants reviewed, Participant #s 2, 3, 4, and 5. This deficient practice was evidenced by the following: 1. On 9/3/25 at 2:00 p.m., the surveyor reviewed the Medical Record (MR) of Participant #2, which revealed that the participant was admitted to the facility in [NJ Ex Order 26.4(b)(1)] with a diagnosis of [NJ Ex Order 26.4(b)(1)]. In addition, the MR revealed that there was no address of the participant's emergency contact on his/her face sheet. 2. At 2:10 p.m. the surveyor reviewed the Medical Record (MR) of Participant #3, which revealed that the participant was admitted to the facility in [NJ Ex Order 26.4(b)(1)] with a diagnosis of [NJ Ex Order 26.4(b)(1)]. In addition, the MR revealed that there was no address of the participant's emergency contact on his/her face sheet. 3. At 2:20 p.m., the surveyor reviewed the	M 701		

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M 701	Continued From page 4 Medical Record (MR) of Participant #4, which revealed that the participant was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1). In addition, the MR revealed that there was no address of the participant's emergency contact on his/her face sheet. 4. At 2:30 p.m., the surveyor reviewed the Medical Record (MR) of Participant #5, which revealed that the participant was admitted to the facility in NJ Ex Order 26.4(b)(1) with a diagnosis of NJ Ex Order 26.4(b)(1). In addition, the MR revealed that there was no address of the participant's emergency contact on his/her face sheet. 5. At 4:30 p.m., the surveyor interviewed the Administrator who stated that the information contained on the participant's face sheet was entered in the facility's electronic database by the facility staff which automatically populated the participant face sheet. During the same interview, the surveyor discussed the missing emergency contact information for the participants reviewed with the Administrator. 6. On 8/14/24 Office of the Inspector General (OIG) conducted a survey at the facility which revealed that, there were no emergency contact addresses for 2 of 2 participants.	M 701			
M 805	8:43F-16.5(a)(b)(c) Infection Control, Santation, Housekeeping (a) The facility shall provide and maintain a sanitary and safe environment for participants. (b) The facility shall provide housekeeping and pest control services.	M 805			

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M 805	Continued From page 5 (c) Written objectives, policies, a procedure manual, an organizational plan, and a quality improvement program for housekeeping, sanitation, and safety services shall be developed and implemented. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a sanitary and safe environment for all participants. This deficient practice was evidenced by the following: 1. On 8/14/24 the Office of the Inspector General (OIG) conducted a survey at the facility and observed dead flies in a facility quiet room by the window and flies throughout the facility. 2. On 9/3/25 at 10:00 a.m., the surveyor toured the facility offices and rooms that had windows but did not see any evidence of dead flies and the surveyor did not observe flies in any other area of the facility. At 3:00 p.m., the surveyor toured the kitchen with the Administrator and facility owner. The surveyor observed overflowing liquid coming from a pipe under the sink, onto the floor, in the facility kitchen area. At 3:05 p.m., the surveyor interviewed the facility owner in the presence of the Administrator, who	M 805			

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M 805	Continued From page 6 stated that the pipes don't fit together properly. He also stated that the liquid leaking from the pipes only occurs when the staff wash a lot of dishes. The Administrator confirmed that there was liquid overflowing from the pipe under the sink onto the floor.	M 805			
M 813	8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages; 2. Nonskid wax shall be used on all waxed floors; 3. All rooms shall be ventilated to help prevent condensation, mold growth, and noxious odors; 4. All participant areas shall be free of noxious odors; 5. Throw rugs or scatter rugs shall not be used in the facility; 6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly;	M 813			

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M 813	Continued From page 7 7. All equipment shall have unobstructed space provided for operation; 8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided; 9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration; 10. Pesticides shall be applied in accordance with N.J.A.C. 7:30; 11. Articles in storage shall be elevated from the floor and away from walls; 12. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room that is used for no other purpose; 13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement; 14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers; 15. Unobstructed aisles shall be provided in storage areas; 16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility;	M 813			

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M 813	Continued From page 8 17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times; 18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insect-proof, rodent-proof, and fire-proof, non-absorbent, watertight containers with tight-fitting covers and collected from storage areas regularly, so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in accordance with N.J.A.C. 8:24; 19. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system; 20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal; 21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof;	M 813		

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M 813	Continued From page 9 22. Wastebaskets and ashtrays shall be made of noncombustible materials; 23. Latex foam pillows shall be prohibited. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a sanitary and safe environment. The deficient practice was evidenced by the following: 1. On 9/3/25 at 10:30 a.m., the surveyor toured the facility and observed scatter rugs on the floor inside the facility and on the ground, by the door in the gazebo area. At 3:05 p.m., the surveyor interviewed the Administrator who confirmed that there were scatter rugs throughout the facility and he knew they were not allowed. 2. On 8/14/24, the Office of the Inspector General (OIG) conducted a survey at the facility and the surveyors provided photographs of their observations: long, unsecured/unprotected hanging long wires in the small quiet room, stage area, former isolation room, private examination	M 813			

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M 825	Continued From page 11 fire extinguisher inspection tags in 11 facility passenger vans which revealed that they were all inspected in February 2025, which was after the OIG's observation on 8/14/24. At 3:30 p.m., the surveyor reviewed an invoice, dated 3/21/24, from an outside vendor used by the facility that inspected their fire extinguishers. The invoice revealed that 30 fire extinguishers were inspected on the buses that were on the property grounds at the time of the inspection. At 3:40 p.m., the surveyor interviewed the facility Director of Transportation (DOT) about the two vehicle fire extinguishers that were not inspected in 2024, the DOT stated that he was not sure how those two got missed. 2. On 8/14/24 the Office of the Inspector General (OIG) conducted a survey at the facility and the surveyors provided photographs of their observations: the facility had two fire extinguishers in two separate passenger vans that had not been examined since March 2023.	M 825			

GOLDEN YEARS CARE, AMDC
108 WOODWARD AVE
MANALAPAN TOWNSHIP, NJ 07726

RESPONSE

NJ DEPARTMENT OF HEALTH
Follow-Up Survey – 09/03/2025
POC Submitted – 10/14/2025
POC Resubmitted – 11/20/2025
POC Resubmitted – 12/08/2025

POC #4
acceptable
12/18/25

TAG# M653 8:43F-14.11: Physical Plant Requirements: The construction, equipment and installation of food service facilities shall meet the requirements of the program.

ELEMENT 1: NO PARTICIPANTS MENTIONED IN THIS DEFICIENCY

ELEMENT 2:

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all clients currently in the Program:

- The Facility will assure all perishable food items are properly stored. This includes safe handling of all perishable food items.

ELEMENT 3:

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility Administrator immediately performed a Facility wide In-Service on 9/4/25 and 9/5/25, with all staff on SAFE FOOD HANDLING FOOD PRACTICES.
- The Facility Administrator In-Serviced on 9/4/25 and 9/5/25 and reviewed SAFE FOOD HANDLING PRACTICES with all kitchen personnel including the Kitchen Supervisor.

ELEMENT 4:

MONITORING PROCEDURE:

Facility will ensure that this deficiency is monitored by implementing the following measures:

- The Facility will monitor overall compliance of Safe Food Handling Food Practices by implementing a Monthly QAPI Audit beginning on 9/5/2025, on Kitchen Sanitation which will include the monitoring of all food items including perishable food items. This will be performed Monthly and must be **completed by the last day of each month beginning in 9/2025**, by the Kitchen Supervisor.
- The Facility will monitor compliance of Safe Food Handling Food Practices by implementing a Quarterly QAPI Audit on Kitchen Sanitation which will include the monitoring of all food items including perishable food items. This will be performed Quarterly by the Dietitian. This report will be presented to Administration at the scheduled Quarterly QAPI Meetings.
- The Monthly/Quarterly QAPI Audits on Kitchen Sanitation will be reviewed Monthly/Quarterly with the Facility Administrator for overall compliance. Any issues will be immediately addressed and resolved.
- All Kitchen Sanitation QAPI Audit's will be presented by the Facility Administrator at the Facilities scheduled Q QAPI Meetings.

COMPLETION DATE:

Completion date of: 10/1/2025

1. In-Servicing completed on 9/4/25 and 9/5/25
2. Monthly and Quarterly QAPI Kitchen Sanitation audits began in September 2025 and completed by 9/30/25

TAG# M701 8:43F-15.3: Medical Records: All participant's Medical Record's need to include the name, address and telephone number of the person to be notified in the event of an emergency.

ELEMENT 1: Participants # 2, 3, 4 and 5 were affected and are now fully corrected and are in compliance.

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

The Facility will meet this standard for all clients by:

- The Facility will assure **all client's** Medical Record's contain an Emergency Contact person including the name, address and telephone number for that Emergency Contact person.
- All **clients including # 2,3,4 and 5** were affected by this and the Facility corrected this on all clients Face Sheets. As a result all clients' Face Sheets, now include Name, Address and Phone Number for all Emergency Contacts.

ELEMENT 2:

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

- The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility audited all clients' Face Sheets in the Program to assure they were corrected if needed and now includes Face Sheets that list, the Name, Address and Phone Number for all Emergency Contacts.

ELEMENT 3:

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility immediately corrected effective date of 9/15/2025, so that all client's Medical Record's now contain:
 - Name of the Emergency Contact Person
 - Address of the Emergency Contact Person
 - Phone Number of the Emergency Contact Person
- The Facility Administrator In-Serviced all necessary staff on 9/5/2025 (Administrative, Nursing, Director of Social Workers and Director of Activities), on this regulation pertaining to Emergency Contact information in each client's Medical Record
- The Facility Administrator assigned the task of auditing to be done and completed by 9/15/2025 by, (Administrative Clerk, Nursing Staff, Director of Social Workers and Director of Activities) of all current client's Medical Records to ensure they now contain the required Emergency Contact documentation. Each staff member was given a list of clients they were responsible for auditing the clients' Face Sheet to assure compliance. This list was compiled by the Facility Administrator to assure all clients charts were audited by 9/15/2025.
- If any Medical Record was found to be deficient in Emergency Contact documentation it was immediately brought to the attention of the Facility Administrator who reviewed it obtained the required Emergency contact documentation and assured, it was documented in the client's Medical Record.
- Currently all clients Medical Record's now contain the required documentation for Emergency contacts.
- Moving forward any new client admitted into the program their Face Sheet will contain the required documentation for Emergency contacts.
- In the event the client has no Emergency contact person to list the Facility will list the clients Primary Care Physician – PCP, as the Emergency contact.
- A new Policy and Procedure effective 9/5/2025 on Emergency Contact documentation was developed by the Administrator as well addressing this requirement.

ELEMENT 4:**MONITORING PROCEDURE:**

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Director of SS will monitor overall compliance of this requirement by performing a Monthly QAPI Audit effective 10/1/2025, on all New Admits, to assure they contain the required Emergency contact documentation
- The Monthly QAPI Audit on Emergency contact documentation in the Medical Record will be reviewed monthly with the Facility Administrator as well
- The Monthly QAPI Audit on Emergency contact documentation in the Medical Record will be presented by the Facility Administrator at the Facilities scheduled Q QAPI Meetings.

COMPLETION DATE:

Completion date of: 10/1/25

1. All necessary staff were In-Serviced by the Facility Administrator, on: 9/5/25
2. All current clients' Medical Records were audited and compliant for Emergency contact documentation by 9/15/25
3. The new Policy and Procedure was developed and implemented on 9/5/25
4. The Monthly QAPI Audits began in 10/1/25

TAG# M805 8:43F-16.5: Infection Control, Sanitation and Housekeeping: The Facility shall provide and maintain sanitary and safe environment for participants, housekeeping and pest control services and written Policies and Procedures for these services.

ELEMENT 1: No participants mentioned in this Deficiency

Element 2:

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility will ensure all areas of the building are sanitary and safe
- The Facility will ensure no dead flies are observed t/o the building
- The Facility will assure the kitchen pipes under the dishwashing sink do not leak and are fitted properly

Element 3:

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility immediately corrected this deficiency. The Facility will provide and maintain a sanitary and safe environment including housekeeping and pest control services as well as written Policies and Procedures for these services.
- The Facility Administrator performed an In-Service on 9/5/2025 with all employees *** including Nursing, Dietary, Social Services, Activities, Transportation, Housekeeping and Administrative on Infection Control, Sanitation and Housekeeping requirements in the AMDC environment.
- The Facility Administrator In-Serviced the Housekeeping personnel on 9/5/2025 as well, on the need to monitor all rooms with or without windows for pest control especially during warmer months when they tend to multiply and be more present in buildings.
- Facility ownership brought in an Exterminator 09/18/2025 to assess and monitor the building for pest control to assess the building.
- Facility ownership immediately brought in a Plumber 09/05/2025 to address the leaking pipes under the sink in the kitchen. This problem was assessed and corrected by the Plumber.

Element 4:

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator will monitor overall compliance in Infection Control, Sanitation and Housekeeping by doing Monthly QAPI Audits, beginning with 9/2025 Monthly Audits to be completed by 9/30/2025. These will be done by: Housekeeping, Supervisor of Housekeeping and Kitchen Personnel, Food Service Supervisor
- The Facility Administrator implemented a Monthly QAPI Audit to be done each month by the last day of the month, on building Infection Control, Sanitation and Housekeeping this includes the monitoring of pest control, both in the building and around the outside perimeter as well.
- The Monthly Infection Control, Sanitation and Housekeeping QAPI Audits will be reviewed each month with Administration for any noncompliance. Any deficient areas will be immediately addressed and corrected by the Facility Administrator.
- Additional reports may be provided by any outside contractors brought in, Plumbers, Pest Control etc .and reviewed by the Facility Administrator as well for compliance and any required follow-up.

- The Monthly Building QA Audits on Infection Control, Sanitation and Housekeeping and any other outside building contractor reports will be presented by the Facility Administrator at the Facilities Q scheduled QAPI Meetings.

COMPLETION DATE:

Completion date of: 10/1/25

1. In-Service for all staff including housekeeping personnel, completed on 9/5/25
2. Monthly QAPI Audits on Infection Control, Sanitation and Housekeeping began September 2025
3. Outside contractors, Exterminator brought in on; 09/18/2025
4. Brought in a Plumber on 09/05/2025

TAG# M813 8:43F-16.7: Infection Control, Sanitation and Housekeeping. The Facility is required to maintain a sanitary and safe environment for all participants.

ELEMENT 1: No participants mentioned in this Deficiency

ELEMENT 2:

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The areas cited to be deficient are all public areas in the building and as a result the Facility has identified that this deficiency has the potential to affect all clients in the program.
- All areas cited and found to be deficient were addressed and corrected.

ELEMENT 3:

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility immediately corrected this deficiency. By assuring the following areas were addressed by Housekeeping, Dietary Personnel, Nursing staff. Transportation staff, basically all staff were In-Serviced 9/5/2025 additional In-Servicing done with client's t/o the month based on client attendance:
 - Scatter rugs were removed from throughout the building interior and exterior
 - Hanging wires including extension cables were immediately addressed and fixed to ensure they were not hanging unsecured and unprotected
 - Garbage bins are organized with no garbage and debris littering the outside of the bins
 - Walkways are unobstructed, no wheelchairs are blocking walkways
- Participants' personal medications are secure and kept in locked cabinets. The Facility Administrator immediately audited on 9/5/2025 the building for scattered rugs *** all were removed, hanging wires, cables or extension cords *** all were addressed and corrected to assure they no longer hang unsecured and unprotected, toured the outside garbage bins to assure the area was litter and debris free, and checked all walkways to assure they were unobstructed.
- The Facility Administrator contacted the contracted **NJ Exec Order 26.4b1** on 9/5/2025 to ensure they come in a timely manner as agreed upon by the written contract the program has with them to assure the garbage is picked up in a timely manner eliminating the possibility of debris being left on the outside of the bins.
- The Facility Administrator implemented a new Policy effective 9/5/2025 on participant's personal medications brought in by the participant and proper storage of them while in the Program.
- The Facility Administrator performed an In-Service on 9/5/2025 with all personnel on Infection Control, Sanitation and Housekeeping, including the importance of not using wheelchairs, walkers or canes to obstruct any walkways. Additionally, the topic of client's personal medications and the need to keep them secure in a locked cabinet was addressed as well

ELEMENT 4:

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility Administrator implemented a Monthly QAPI Audit effective for 9/2025 and completed by 9/30/2025 on Infection Control, Sanitation and Housekeeping. This includes use of extension cords, outside garbage bins and walkways in the building. This will be done by Facility Administrator.
- Additionally, the Facility Administrator also implemented a new Monthly QAPI Audit effective 9/2025 and completed on 9/30/2025 on participant personal Medications brought in and proper storage of them. This will be done by the Nursing Department. This Audit will be reviewed monthly for compliance with the Facility Administrator
- Both Monthly Reports on: Infection Control, Sanitation and Housekeeping. will be presented by the Facility Administrator at the Facilities Q scheduled QAPI Meetings.

COMPLETION DATE:

Completion date of: 10/1/25

1. New Policy and Procedure for clients' personal medications brought into the program completed on 9/5/25
2. In-Services done with employees on 9/5/25
3. In-Services done with client's t/o the month of September 2025, to assure all clients are educated on proper storage of personal medications brought into the program as well as where to safely store wheelchairs, walkers etc. To allow walkways to be free and clear.
4. QAPI Audits began effective month of September 2025
5. Contracted Trash Company contacted 9/5/25

TAG# M825 8:43F-17.1: Transportation Services: The Facility shall maintain vehicles in safe operating order.

ELEMENT 1: No participants mentioned in this Deficiency

CORRECTIVE ACTION FOR THOSE CLIENTS AFFECTED BY THE DEFICIENT PRACTICE:

ELEMENT 2:

HOW THE FACILITY WILL IDENTIFY OTHER CLIENTS, WHO HAVE THE POTENTIAL TO BE AFFECTED BY DEFICIENT PRACTICE:

The Facility identifies that this deficiency can affect all other clients in the program, so all clients technically have the potential to be affected by this deficient practice. The Facility will meet this standard for all clients by:

- The Facility Administrator will ensure that all fire extinguishers throughout the building and those on all vehicles are inspected annually and that this is documented on the individual fire extinguisher inspection tag.

ELEMENT 3:

SYSTEMIC CHANGES IMPLEMENTED TO ASSURE THE DEFICIENT PRACTICE DOES NOT OCCUR:

- The Facility corrected this deficiency. The Facility Administrator will ensure that all fire extinguishers are located throughout the building and those on the transportation vehicles are inspected annually.
- The Facility Administrator will continue to have an outside vendor come in to inspect all fire extinguishers including all located on the vehicle transportation vehicles.
- The Facility Administrator contacted the outside vendor who does this audit to review the deficiency as well
- The Facility Administrator provided In-Servicing 9/5/2025, on this requirement to all Transportation employees including the Dir of Transportation (DOT).

ELEMENT 4:

MONITORING PROCEDURE:

The Facility will ensure that this deficiency is being monitored by implementing the following measures:

- The Facility will implement an Annual QAPI Audit effective 9/2025 and completed for 2025 by 9/30/2025. Moving forward this audit will be completed annually every January by the 31st of that month, on Fire Extinguisher compliance including annual monitoring and documentation of this on the extinguisher's inspection tag. This will be done by the Facility Administrator.
- The Facility Administrator will monitor fire extinguisher compliance including those located on the transportation vehicles by having an outside company come in annually to inspect all Fire Extinguishers including documenting review dates on the individual inspection tags. This Annual QAPI Audit, once completed by 1/31 of each year, will be reviewed for compliance by the Facility Administrator by the 31st of January on an annual basis.
- The Fire Extinguisher Audits will be presented by the Facility Administrator, at the Facilities Q scheduled QAPI Meetings.

COMPLETION DATE:

Completion date of: 10/1/25

1. New Policy and Procedure for clients' personal medications brought into the program completed on 9/5/25
2. In-Services done with employees on 9/5/25
3. In-Services done with client's t/o the month of September 2025, to assure all clients are educated on proper storage of personal medications brought into the program as well as where to safely store wheelchairs, walkers etc. To allow walkways to be free and clear.
4. QAPI Audits began effective month of September 2025
5. Contracted Trash Company contacted 9/5/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 13001	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/8/2025
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 M0653	Correction	ID Prefix M0701	Correction	ID Prefix M0805	Correction
Reg. # 8:43F-14.11(a)(1-3)(i-ii), (4-7)	Completed	Reg. # 8:43F-15.3(a)(1)	Completed	Reg. # 8:43F-16.5(a)(b)(c)	Completed
LSC	10/01/2025	LSC	10/01/2025	LSC	10/01/2025
ID Prefix M0813	Correction	ID Prefix M0825	Correction	ID Prefix	Correction
Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. # 8:43F-17.1(c)(d)(e)	Completed	Reg. #	Completed
LSC	10/01/2025	LSC	10/01/2025	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 9/3/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
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