STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	**104 PENSION 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) COMPLETION DATE
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 03/05/2024 and 03/06/2024 and was found to be in noncompliance with the requirements for participation in Medicare/ Medicaid at 42 CFR (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 Manalapan is a 1-story building that was built in the 1980's, it is composed of Type I fire resistant construction. The facility is divided into 7- smoke zones. The facility has a 600 KW Diesel Emergency Generator that supplies power to 100 % of the building. The facility is Licensed for 132 certified beds.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available	K 222		4/16/24

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

Electronically Signed | 03/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 222	Continued From page 1 to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout	K 222		

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	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	**104 PENSION ROAD** **MANALAPAN, NJ 07726**

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K 222	Continued From page 2 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 03/05/2024 and 03/06/2024, it was determined that the facility failed to provide 1 of 9 designated exit discharge (illuminated exit signs above door) doors with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 03/05/2024 (day one of survey) during the survey entrance at approximately 9:04 AM, a request was made to the Director of Maintenance and Environmental Services (DMES) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with nine (9) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:21 AM on 03/05/2024 and continued on 03/06/2024 in the presence of the facility's DMES a tour of the building was conducted.	K 222	K222 SS-E 1. Corrective Action: " On March 20, 2024, a plate was installed to disable the thumb turn lock and fastening device on the egress side of the main entrance sliding door, which is now disengaged. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The maintenance director will do weekly audits of the main entrance sliding doors to assure that the thumb turn lock is disengaged. 4. How Will These Actions Be Measured: " The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

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EXCEL CARE AT MANALAPAN	**104 PENSION ROAD** **MANALAPAN, NJ 07726**

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K 222	Continued From page 3 On 03/05/2024 at approximately 10:09 AM, the surveyor observed the Main Entrance double automatic sliding set of exit discharge doors (illuminated exit signs above doors)revealed a thumb turn lock on the egress side of the doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit. A review of an emergency evacuation diagram posted in the corridor identify the set of double doors are the primary doors to reach an exit discharge in the event of an emergency. The Main Entrance set of double automatic doors had a sign to open doors that states "Push in case of an Emergency." The DMES confirmed the findings at the times of observation. The Administrator was informed of the deficiency during the survey exit on 03/06/2024 at approximately 1:30 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 12/12/2023 and 12/14/2023 in the presence of facility management, it was determined that the facility failed to: 1) Provide a functioning battery backup emergency lighting in 1 of 3 rooms the	K 291	SS-E 1. Corrective Action: " Upon identification on March 19, 2024, a light with a battery backup independent of the emergency generator was installed.	4/16/24

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K 291	Continued From page 4 emergency generator's transfer three (3) switch locations, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 03/05/2024 (day one of survey) during the survey entrance at approximately 9:04 AM, a request was made to the Director of Maintenance and Environmental Services (DMES) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested, does the facility have an emergency generator. The DMES told the surveyor, yes we have an 600 KW Diesel Emergency Generator. A review of the facility provided lay-out identified the facility is a single-story (1) building with basement. Starting at approximately 9:21 AM on 03/05/2024 a tour of the facility was conducted. During the building tour at approximately 9:36 AM, an inspection inside the basement Electrical room, where one (1) of five (5) Emergency Generators transfer switches (Onan transfer switch) was located was performed. The surveyor observed no evidence of a battery back-up emergency light independent of the emergency generator. The surveyor made a request to the DMES do you have a battery back-up emergency light for the "Onan" generator transfer switch. The DMES told the surveyor, no. The surveyor observed that the "Onan" transfer switch indicator light was on and read Normal and Connected. The surveyor also observed an	K 291	2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The maintenance director will perform monthly audits to assure the battery backup light for the emergency generator is present and operational. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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K 291	Continued From page 5 electrical panel to the left was connected to the transfer switch, that had breaker slot #21 indicated it was for the buildings Fire Alarm and Detection system. The DMES confirmed the findings at the times of observation. The Administrator was informed of the deficiency during the survey exit on 03/06/2024 at approximately 1:30 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier 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	K 321		4/16/24

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K 321	Continued From page 6 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 observation and review of facility provided documentation on 03/05/2024 and 03/06/2024, in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 03/05/2024 (day one of survey) during the survey entrance at approximately 9:04 AM, a request was made to the Director of Maintenance and Environmental Services (DMES) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with a basement. Starting at approximately 9:21 AM on 03/05/2024 and continued on 03/06/2024 in the presence of the facility's DMES a tour of the building was conducted.	K 321	K321 SS-E 1. Corrective Action: " On March 28, 2024, a self-closing device was installed on the corridor door leading to the physical therapy department. " On March 20, 2024, the maintenance designee audited all fire rated doors to assure they self-closed. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The maintenance director will perform weekly audits of all fire rated doors to assure they self-close. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next	

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K 321	Continued From page 7 During the two (2) day building tour the surveyor observed the following hazardous area that failed to have smoke resisting doors, On 03/06/2024: 1) At approximately 12:34 PM, during an inspection of an office located adjacent to the lobby area was performed. This office had a glass door leading to the lobby and a second door that opened to the exit access corridor leading to the Physical Therapy area of the facility. When the corridor door leading to the Physical Therapy area was opened to a 90 degree opening to the frame and allowed to self-close the door did not self-close. This left a 33 inch opening from the room to the exit access corridor. The surveyor observed inside the room the following combustible products, - 33 cases of Cover Gowns (50 gowns per case). - 6 cases of Plastic Aprons. - 28 cases of Vinyl Synthetic Exam Gloves. - Multiple combustible cardboard boxes and other combustible products. This office was utilized as a Personal Protective Equipment storage room. At this time the surveyor measured and recorded the room 11"- 10" by 11"- 8". The room measured 137 square feet which is larger than 50 square feet. With this corridor door not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The DMES confirmed the findings at the times of	K 321	Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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K 321	Continued From page 8 observation. The Administrator was informed of the deficiency during the survey exit on 03/06/2024 at approximately 1:30 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 355 SS=E	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 observation, interview and review of facility documentation on 03/05/2024 and 03/06/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly visual examination inspection for 6 of 28 portable fire extinguishers observed and inspected, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and	K 355	K 355 SS-E 1. Corrective Action: " Upon identification, the identified fire extinguishers that did not have a monthly inspection were inspected and dated to bring them into compliance. " An audit of all fire extinguishers was performed by the maintenance designee to assure the fire extinguishers were inspected and in compliance. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The maintenance director and/or designee will audit on a monthly basis the	4/16/24

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K 355	Continued From page 9 there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 03/05/2024 (day one of survey) during the survey entrance at approximately 9:12 AM, a request was made to the Director of Maintenance and Environmental Services (DMES) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with a basement. During the two (2) day tour of the facility the surveyor observed and inspected twenty-eight (28) portable fire extinguishers in various locations that were annually inspected November 2023 with the following, On 03/05/2024: 1) At approximately 9:59 AM, the surveyor	K 355	fire extinguishers to assure they are inspected and dated monthly. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

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K 355	Continued From page 10 observed inside the basement Maintenance room five (5) "ABC-Type" fire extinguishers and one (1) "Class K-Type" wet chemical fire extinguisher being stored on the floor. At this time the surveyor asked the DMES are these six (6) fire extinguishers spare fire extinguishers. The DMES told the surveyor, yes they are. Further inspection identified on the inspection tags attached to the five (5) "ABC-Type" and one (1) "Class K-Type" fire extinguishers were last annually inspected November 2023 with no evidence of a monthly visual examination being performed and documented on the tags for December 2023, January and February 2024. The DMES confirmed the findings at the times of observation. The Administrator was informed of the deficiency during the survey exit on 03/06/2024 at approximately 1:30 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
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		4/16/24

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EXCEL CARE AT MANALAPAN	**104 PENSION ROAD** **MANALAPAN, NJ 07726**

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K 521	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations on 03/05/2024 and 03/06/2024 in the presence of facility management, it was determined that the facility failed to : 1) Ensure that the facility's ventilation systems were being properly maintained for 4 of 8 Resident bathroom exhaust systems, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 03/05/2024 (day one of survey) during the survey entrance at approximately 9:04 AM, a request was made to the Director of Maintenance and Environmental Services (DMES) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also requested how many Resident sleeping rooms are in the facility. The DMES was not sure how many Resident sleeping rooms there were in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-six (66) Resident sleeping rooms. Starting at approximately 9:21 AM on 03/05/2024 and continued on 03/06/2024 in presence of the facility's DMES a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor inspected eight (8) Resident sleeping room bathrooms. This inspection identified when the bathroom	K 521	K521 SS-E 1. Corrective Action: " On March 22nd the HVAC company serviced the facility to address the bathroom exhaust fans, ordered parts and will have it fully repaired by April 16, 2024. " An audit of all bathroom exhaust vents was performed by the maintenance designee to assure the Bathroom exhaust fans were inspected and in compliance. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The maintenance director and/or designee will audit on a monthly basis the bathroom exhaust fans to assure they function properly. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	**104 PENSION ROAD** **MANALAPAN, NJ 07726**

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K 521	Continued From page 12 exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 8 resident bathrooms in the following locations: On 03/05/2024: 1. At approximately 10:54 AM, in Resident room #101 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 11:25 AM, in Resident room #110 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. On 03/06/2024: 3. At approximately 10:29 AM, in Resident room #222 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 4. At approximately 10:29 AM, in Resident room #222 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The DMES confirmed the findings at the times of observation.	K 521		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	**104 PENSION ROAD** **MANALAPAN, NJ 07726**

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K 521	Continued From page 13 The Administrator was informed of the deficiency during the survey exit on 03/06/2024 at approximately 1:30 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 03/05/2024 and 03/06/2024, in the presence of facility management, it was determined that the facility failed to ensure that 3 of 13 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection	K 911	K911 SS-D 1. Corrective Action: " Upon identification, the 3 electric outlets, located in the salon, the main kitchen and the 100-wing soiled utility room were replaced with working GFI receptacles. " The maintenance designee, on March 19, 2024, audited all areas requiring a GFI receptacle to assure they de-energize. 2. Identification of other residents or areas having the potential to be affected due to the nature of the deficiency: " All residents have the potential to be affected by this deficient practice. 3. Measures Put into Place: " The maintenance director and/or designee will do monthly audits of all	4/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	**104 PENSION ROAD** **MANALAPAN, NJ 07726**

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K 911	Continued From page 14 for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 03/05/2024 (day one of survey) during the survey entrance at approximately 9:04 AM, a request was made to the Director of Maintenance and Environmental Services (DMES) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1) building with sixty-six (66) Resident sleeping rooms, common areas and offices. Starting at approximately 9:21 AM on 03/05/2024 and continued on 03/06/2024 in presence of the facility's DMES a tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested thirteen (13) electrical outlets in wet (with-in 6 feet of a sink) locations with three (3)electrical outlets that failed to de-energize when tested in the following location, On 03/05/2024:	K 911	areas requiring a gfi receptacle to assure they all de-energize. 4. How Will These Actions Be Measured: " The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting monthly for 6 months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on April 16, 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315282	A. BUILDING **01** B. WING _____	**03/06/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 911	Continued From page 15 1. At approximately 11:11 AM, the surveyor observed, measured and recorded in the "100's-Wing" Soiled Utility room, one (1) Duplex electrical outlet located 4 feet to the right of the sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. On 03/06/2024: 2. At approximately 11:00 AM, the surveyor observed, measured and recorded in the Residents Salon, one (1) Duplex electrical outlet located 3 feet to the left of the hair washing sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. 3. At approximately 12:05 PM, the surveyor observed, measured and recorded in the Main Kitchen, one (1) Duplex electrical outlet located 34 inches to the right of the deep well prep sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The DMES confirmed the findings at the times of the observations. The Administrator was informed of the deficiency during the survey exit on 03/06/2024 at approximately 1:30 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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
315282 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/1/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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	K0222	04/16/2024	LSC	K0291	04/16/2024	LSC	K0321	04/16/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0355	04/16/2024	LSC	K0521	04/16/2024	LSC	K0911	04/16/2024
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	
3/6/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO