STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315282		C 11/23/2021

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
F 000	INITIAL COMMENTS	F 000		
	Complaint # NJ 144248 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint visit. Survey Date: 11/23/21 Census: 54 Sample: 14+6 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.			
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		12/31/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/08/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint # NJ00144248 Based on interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to notify the responsible party (RP) of a resident's change in condition for 1 of 3 residents reviewed (Resident	F 580	1. Corrective action for residents found to be affected by deficient practice. -Resident [redacted] expired in [redacted]. No corrective action for this residents 2. Identification of other residents with	

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F 580	Continued From page 2 [redacted]). This deficient practice was evidenced by: According to the Admission Record, Resident [redacted] was admitted in [redacted] with diagnoses which included but were not limited to: [redacted]. A review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted] "which indicated the resident's cognition was [redacted]. A review of the Physician orders revealed the resident had a [redacted] order. A review of the nursing progress notes revealed the following: On 04/11/2020 at 5:10 PM, the Registered Nurse Supervisor (RNS) documented that Resident [redacted] appeared [redacted] and [redacted]. The MD ordered [redacted] for [redacted] days for [redacted] and [redacted] for [redacted] days. On 04/12/2020 at 2:26 PM, the RNS documented the resident refused to eat dinner, and the [redacted] was [redacted] in the resident's [redacted]. On 04/13/2020 at 1:34 PM, the Licensed Practical Nurse (LPN) #1 documented the [redacted] were	F 580	potential to be affected by deficient practice. -Residents with a change in condition have the potential to be affected by the same deficient practice. -The Director of Nursing and Nursing Supervisors reviewed the 24-hour report to identify current residents who have a significant change in condition and to ensure that their respective Responsible Parties are notified. 3. Measures put into place to ensure the deficient practice will not recur. -A Policy and Procedure regarding “Notification of Change in Condition” was developed and implemented by facility’s new ownership (Change of Facility Ownership took effect on 12/27/2021). -All nursing staff and the Interdisciplinary Team will be in-serviced on the facility’s policy on “Notification of Change in Condition”. Emphasis will be made in ensuring that residents’ representative/ responsible party is notified of any significant change(s) in resident’s condition.	

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F 580	Continued From page 3 [redacted], and the resident's appetite remained poor. On 04/14/2020 at 08:48 AM, the LPN #1 documented the resident had difficulty [redacted], refused all medications, and the [redacted] was [redacted] On 04/15/2020 at 06:55 AM, the LPN #2 documented the resident was found [redacted] and [redacted], and MD and the family were notified. There was no documentation in the medical record that the resident's responsible party was notified of the resident's change in condition from [redacted] through [redacted] . During an interview with the surveyor on 11/22/2021 at 09:41 AM, the Licensed Practical Nurse Unit Manager (LPN/UM) stated the family are notified of any change in condition and would be documented in the nurse's notes. During an interview with the surveyor on 11/22/21 at 09:55 AM, the Registered Nurse (RN) stated the process for change in condition would be to call the MD to get instructions then call the family because it was the facility's policy. During an interview with the surveyor on 11/22/2021 at 10:10 AM, the RNS stated that when there was a change in condition, she would notify the doctor, notify the family, and document in the resident's medical record within 24 hours. She stated it was not the facility's policy, but it was standard nursing practice, and stated she always called the family.	F 580	4. How will facility monitor corrective action to ensure deficient practice will not recur. -The Director of Nursing or designee Designee will conduct medical record audits on 5 residents with Significant Change(s) in Condition weekly x 4 weeks, and then monthly thereafter x 3 months. Audit will consist of making sure that the resident representative/responsible party was notified regarding the resident's change in condition. Any issues will be corrected immediately. -Findings will be reported to the Administrator monthly and will be presented in quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans.	

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	315282		C 11/23/2021

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F 580	Continued From page 4 At that time, the surveyor reviewed the resident's progress notes with the RNS. The RNS did not know why she did not document the resident's change in condition in the progress notes. However, she stated it was during the "height of Covid". During an interview with the surveyor on 11/22/2021 at 10:30 AM, the DON stated that when a resident had a change of condition, the family would always be notified and it would be documented in the progress notes. On 11/22/2021 at 02:07 PM, the Administrator, DON was notified of the findings. On 11/23/2021 at 09:23 AM, the Administrator, in the presence of the DON stated that the change in the resident's condition was not reported to the family and should have been. Review of the facility's policy labeled "Change in a Resident's Condition or Status" dated March 2013 with a revised date of 12/18/2014 revealed the nurse supervisor would notify the resident's next of kin or representative when there was a significant change in the resident physical or emotional or mental condition. N.J.A.C. 8:39-5.1(a)	F 580		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 761		1/10/22

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F 761	Continued From page 5 instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of facility documentation, it was determined the facility failed to a.) maintain medications with appropriate labeling and b.) maintain a clean, orderly medication cart for 2 of the 3 carts observed on 2 of 2 nursing units. This deficient practice was evidenced by the following: On 11/18/21 from 11:19 to 11:54 AM, in the presence of the Registered Nurse (RN) #1, the surveyor observed the following in the medication cart labeled [redacted] on the [redacted] unit: 1. In the first row of the second drawer, there were two yellow oval tablets, one pink oval tablet,	F 761	1. Corrective action for residents found to be affected by deficient practice. -No residents were directly affected by the deficient practice. The loose pills found in Medication Cart [redacted] on the [redacted] unit and the Medication Cart on the [redacted] unit were destroyed using the drug buster. Both medication carts were immediately cleaned and organized by the nurses. -Involved Nursing Staff were immediately counseled and educated on the facility's protocol re: the following:	

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F 761	Continued From page 6 one large white oval tablet, one small white oval tablet, and one white round tablet which were unwrapped and unmarked. There was also paper debris. 2. In the third row of the second drawer, there was one large pink oval tablet, seven white oval tablets, six small white round tablets, one small pink oval tablet, two pink round tablets, one green round tablet, and two yellow oval tablets which were unwrapped and unmarked. There was also paper and foil debris. 3. In the fourth row of the second drawer there was one large white tablet, three yellow oval tablets, one blue oval tablet, three white round tablets, two white oval tablets, and one peach round tablet which were unwrapped and unmarked. There was also paper and foil debris. During an interview with the surveyor at that time, RN #1 stated the nurse cleaned the medication cart when they started their shift and that the loose medications should not have been in the drawer. RN #1 further stated that the unit manager should be notified and that the medications would be destroyed using the drug buster so that they were not given to a resident. On 11/18/21 from 12:32 to 01:08 PM, in the presence of RN #2, the surveyor observed the following in the medication cart for the [redacted] unit: 1. In the first row of the second drawer, there were two white round tablets, one peach round tablet, and one blue half tablet which were unwrapped and unmarked. There was also debris.	F 761	(a) Maintain medications with appropriate labeling at all times; (b) Promptly dispose medications without secure closures, in accordance with facility's procedures for medication disposal/destruction; and (c) Ensure that the Medication Cart is cleaned and organized every shift. 2. Identification of other residents with potential to be affected by deficient practice. -All residents have the potential to be affected by this deficient practice. 3. Measures put into place to ensure the deficient practice will not recur. -All nurses were educated on the facility's policies re: "Proper Labeling and Storage of Medications" and "Medication Disposal/Destruction". Emphasis was made on the following: (a) Maintain medications with appropriate labeling at all times;(b) Promptly dispose medications without secure closures, in accordance with facility's procedures for medication disposal/destruction;and (c)Ensure that the Medication Cart is cleaned and organized every shift. 4. How will facility monitor corrective action to ensure deficient practice will not	

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F 761	Continued From page 7 2. In the second row of the second drawer, there were two white round tablets, one peach round tablet, and one peach half tablet which were unwrapped and unmarked. There was also paper and foil debris. During an interview with the surveyor at that time, RN #2 stated it was the nurse's responsibility to clean the cart each shift and that she was unsure why the pills were loose in the drawers and that she would destroy them in the drug buster. RN #2 further stated it was important to account for all of the medications for each resident and to correctly refill the cart when medications were received from the pharmacy. Review of the facility's policy titled "Medication Storage in the Facility," dated 8/28/2007, included but was not limited to; "Procedure 1. The provider pharmacy dispenses medications in containers that meet legal requirements, including requirements of good manufacturing practices. Medications are kept in these containers. 13. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy ...14. Medication storage areas are kept clean, well-lit, and free of clutter..." NJAC 8:39-29.4(a),(h)	F 761	recur. -The Unit Manager/Nursing Supervisor or Designee will conduct Observation Audits of all the Medication Carts once a week for 4 weeks; then monthly x 3 months. Audit will focus on determining compliance with (a) Appropriate Labeling and Storage of Medications; (b) Prompt disposal of medications without secure closures; and (c) Maintenance of clean and orderly Medication Carts -Audit Findings will be reported to the Director of Nursing on a monthly basis and reported at the Quarterly Quality Assurance Meeting. The QAPI (Quality Assurance and Performance Improvement) Committee will determine the need for further audits and/or action plans	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		12/12/21

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F 812	Continued From page 8 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and other facility documentation, it was determined that the facility failed to ensure that kitchen staff were properly trained and capable of performing assigned duties to maintain proper kitchen sanitation and prevent food-borne illness. This deficient practice was evidenced by: During the initial tour of the kitchen on 11/17/21 from 09:47 AM until 10:34 AM, the surveyor observed the following in the presence of the Director of Dining Services (DDS): During an interview with the surveyor at 10:16 AM, the DDS stated that a high temperature dish machine was utilized, and the required wash temperature was 150 degrees or higher and the required final rinse temperature was 180 degrees. The surveyor reviewed the Dish Machine	F 812	1. Corrective action for residents found to be affected by deficient practice. -no specific identified residents were identified by this alleged deficient practice 2. Identification of other residents with potential to be affected by deficient practice. -All residents could be affected by the alleged deficient practice. 3. Measures put into place to ensure the deficient practice will not recur. -The DDS completed immediate in-servicing for staff responsible for the dish machine function and completed competencies on the proper function and	

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F 812	Continued From page 9 Temperature log for the month of November 2021 which revealed that the required rinse temperature of 180 degrees was not met during all recorded breakfast and lunch washes from 11/1/21 through 11/16/21 and only met the rinse requirement during dinner on 11/01/21, 11/03/21, and 11/08/21. Review of the October 2021 Dish Machine Temperature log revealed that the required rinse temperature of 180 degrees was not met during the recorded breakfast readings from 10/01/21 through 10/31/21 and was only met during the recorded lunch readings on 10/03/21, 10/09/21,10/17/21, 10/24/21 and during the recorded dinner readings on 10/01/21 10/03/21, 10/04/21, 10/07/21, 10/11/21, 10/12/21, 10/13/21, 10/14/21, 10/15/21, 10/16/21, 10/17/21, 10/18/21, 10/20/21 and 10/25/21 through 10/31/21. At that time, the DDS stated that she was responsible to review the Dish Machine Temperatures and when she last reviewed it a couple of days ago, she did not notice that the final rinse temperatures were recorded at values less than 180 degrees as required. She further stated that the dishes were not sanitized if the final rinse temperature of 180 degrees was not met. During an interview with the surveyor at 10:19 AM, The Dietary Aide (DA) ran the dish machine to demonstrate function in the presence of the surveyor and the DDS. He stated that the wash temperature should be 158 degrees and the final rinse temperature should be 189 degrees. He stated that the rinse cycle usually ran at 172 degrees. When the surveyor asked if the dishes were sanitized when the final rinse cycle was 172 degrees he stated, "Yes, because the water got hot and burned." The DA stated that the dishes were sanitized if the final rinse cycle measured 172 degrees. He stated that the dish machine	F 812	temperature required to assure sanitizing of the dishes and the documentation on the dish machine temperature logs. -The DDS will assure new hire orientation will include education on proper dish machine function, and competency assessment to confirm proper temperatures are reached in the dish washing final rinse cycle of the dish machine and documentation on the log of same. 4. How will facility monitor corrective action to ensure deficient practice will not recur. -The DDS/designee will complete a detailed review of the dish machine function and documentation on the dish machine temperature logs for compliance with sanitation daily. -results of the daily reviews will be reported at the monthly QAPI meetings for QAPI committee review to assure compliance.	

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F 812	Continued From page 10 went down a couple of months ago and he received an in-service on dish machine usage and function at that time. The DA then ran the dish machine and stated that the wash temperature was 162 degrees, and the final rinse was 172 degrees. At that time, the surveyor observed that the final rinse temperature was 192 degrees and was not accurately identified by the DA who instead reviewed the rinse temperature, instead of the final rinse temperature value. When interviewed, the DA stated that final rinse was not being recorded, and the rinse tank temperature which preceded the final rinse cycle, was recorded instead when he completed the Dish Machine Temperature log. During an interview with the surveyor on 11/19/21 at 12:33 PM, the DDS stated that she should have paid more attention to the dish machine temperature logs. She stated that she confirmed that the staff recorded rinse temperature on the Dish Machine Temperature logs for the month of October and November 2021 instead of the final rinse temperatures as required. She stated that she phoned the repair technician previously when the temperature readings were observed to be low, and the technician determined that the dish machine met the required temperatures for sanitization. She stated that competencies were not done with the Dietary Aides for dish machine use and related documentation. She further stated that she had not yet conducted employee in-services to confirm that the Dietary Aides knew how to properly check the dish machine temperatures since 11/17/21 when the surveyor observed the dish machine function. During an interview with the surveyor on 11/23/21 at 9:34 AM, the Licensed Nursing Home	F 812		

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EXCEL CARE AT MANALAPAN	104 PENSION ROAD MANALAPAN, NJ 07726

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F 812	Continued From page 11 Administrator (LNHA) stated that though the DA had an in-service related to pot washing and dishwashing on 09/21/21, he should have had a competency done upon hire. She stated that the DDS also should have reviewed the Dish Machine Temperature logs daily to ensure that the dish machine functioned properly. Review of the Dishwashing Policy (reviewed 02/20/2017) revealed the following: Use the steps in the following procedure to instruct and demonstrate to staff for training purposes. Procedure: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. A. High Temp dishwashers (wash 150, rinse 180) ...If temperature does not meet requirements for a high or low temp machine as noted above ...alert your DDS and/or the maintenance director for further instruction ... Director of Dining Services will spot check dish machine temperature log to assure proper sanitizing of dishes. NJAC 8:39-17.2(g) and 19.7(d)	F 812		