STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Complaint #: 182825, 182275,186012,2585839, 2650138 Census: 102 Sample Size: 9 A complaint survey was conducted on 10/27/2025 through 10/29/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR 483.25(d)(1)(2) F 689, as the facility failed to provide adequate supervision to a NJ Ex Order 26, 4B1 resident (Resident #2) with a known history of NJ Ex Order 26, 4B1, who NJ Ex Order 2 from the facility on NJ Ex Order 26, 4B1 On NJ Ex Order 26, 4B1, the Licensed Practical Nurse (LPN #1) noticed Resident #2 was NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. LPN #1 initiated a search, and a visiting family (VF #1) of another resident stated that they observed a [gender redacted] NJ Ex Order 26, 4B1, and LPN #1 and other staff NJ Ex Order 26, 4B1 for Resident #2. While outside the facility, VF #2, who was at the facility's NJ Ex Order 26, 4B1 directed the staff to search down NJ Ex Order 26, 4B1. LPN #1 stated during an interview with the surveyor on 10/27/2025, that the resident was NJ Ex Order 26, 4B1 NJ Ex Order 26, NJ Ex Order 26, 4B1NJ Ex Order 26, 4B1 in the company of two women who stated the resident looked NJ Ex Order 26, 4B1. The resident was NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 at NJ Ex Order 26, 4B1, assessed with NJ Ex The Administration was notified of the F 689 IJ and provided the IJ template on 10/27/2025 at 5:15 PM. An acceptable Removal Plan (RP) was received on 10/28/2025 at 12:30 PM indicating the action the facility will take to prevent serious harm from	F0000		11/20/2025

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F0000	Continued from page 1 occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice to include: on NJ Ex Order 26, 4B1, Resident #2 was NJ Ex Order 26, 4B1, their NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1, the resident was assessed with NJ E NJ Ex Order 2 and NJ Ex Order 26, 4B1. On 10/19/2025, the U. S. FOIA (b) (2) checked doors, elevators, and NJ Ex Order 26, 4B1 systems to NJ Ex Order 26, 4B1, and identified a NJ Ex Order 26, 4B1 in a non-residential area and secured with alarm. On 10/19/2025, the facility began an investigation, and NJ Ex Order 26, 4B1 were tested. On 10/27/2025, the "Neighborhood Watch" list with residents' photos was updated, an NJ Ex Order 26, 4B1 was conducted, Certified Nursing Aide (CNA) assignments were updated to include identification of residents at NJ Ex Order 26, 4B1, and all staff were educated on NJ Ex Order 26, 4B1 The surveyor verified the implementation of the Removal Plan on-site and determined the immediacy was removed as of 10/29/2025 at 2:00 PM.	F0000		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Complaint # 265013 Based on interviews and review of other pertinent facility documents on NJ Ex Order 26, 4B1, it was determined that the facility failed to ensure the nursing staff documented a resident's (Resident #2) NJ Ex Order 26, 4B1 from the facility in the resident's medical record in accordance with professional standards of practice. This deficient practice was identified for 1 of 4 residents reviewed for NJ Ex Order 26, 4B1 (Resident #2). Reference: New Jersey Statutes, Annotated Title 45 Chapter 11, Nursing Board. The Nurse Practice Act for the State of New Jersey states; "the practice of nursing as a Registered Professional Nurse is defined as diagnosing, and treating human response to actual or potential physical and emotional health problems,	F0658	1. Corrective Action for the Affected Resident Resident #2's medical record has been updated to include complete nursing documentation for the elopement incident that occurred on NJ Ex Order 26, 4B1 A late entry note was completed noting the timeline, assessment, interventions, notifications, and post incident supervision. 2. Identification of Other Residents Who May Be Affected A 100% audit was completed for all residents with elopement risk, wandering behaviors, or electronic supervision devices. Documentation has been corrected where needed. 3. Systemic Changes to Prevent Recurrence A. Policy Review and Education • Nursing Documentation Policy was revised to include mandatory documentation of all elopement-related events. • Mandatory in service education completed for all licensed nurses. B. Documentation Checklist	11/20/2025

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F0658 SS = D	Continued from page 2 through such services as case finding, health teaching, health counseling, and provision of care supportive to restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized Physician or dentist." Reference: "The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized Physician or Dentist." The evidence was as follows: A review of the Facility Reportable Event (FRE) dated NJ Ex Order 26.4(b)(1), that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that on NJ Ex Order 26.4(b)(1), at approximately 2:40 PM, Resident #2 was NJ Ex Order 26, 4B1 the resident was NJ Ex Order 26, 4B1 An NJ Ex Order 26, 4B1 protocol was initiated, and the NJ Ex Order 2 . While the NJ Ex Order 26, 4B1 , a visiting family member (VF #1) [of another resident] stated that NJ Ex Order 26, 4B1 The facility staff prompted a NJ Ex Order 26, 4B1 of the facility and NJ Ex Order Resident #2 in the NJ Ex Order 26, 4B1 . At NJ Ex Order 26, 4B1 , the resident NJ Ex Order 26, 4B1 , and their NJ Ex Order 26, 4B1 was NJ Ex Order 26, 4B1 . A NJ Ex Order 26, 4B1 was completed, and NJ Ex Order 26, 4B1 were noted. At 3:00 PM, Resident #2's doctor and family were notified, and the resident was placed on NJ Ex Order 26, 4B1 According to the Admission Record face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B1 . According to the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B1 Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Or which indicated the resident's NJ Ex Order 26, 4B1	F0658	Continued from page 2 • A checklist was implemented for all incident reports requiring documentation of assessments, notifications, interventions, and care plan updates. C. Enhanced Surveillance • RN Supervisor completes a 24 hour documentation review for all incidents. 4. Monitoring to Ensure Ongoing Compliance Daily audits × 4 weeks, weekly audits × 8 weeks, and monthly audits × 3 months will be performed. Results will be reviewed in QAPI.	

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F0658 SS = D	Continued from page 3 A review of Resident #2's Care Plan (CP) with an initiated date of NJ Ex Order 26, 4B1, revealed that the resident had a NJ Ex Order 26, 4B1 related to (r/t) NJ Ex Order 26, 4B1. The CP also indicated that Resident #2 had a NJ Ex Order 26, 4B1 placed on their NJ Ex Order 26, and that the resident should be engaged in purposeful activity. A review of Resident #2's Progress Notes included a Nurse's Progress Note dated NJ Ex Order 26, 4B1 with an effective date of NJ Ex Order 26, 4B1 written by the Licensed Practical Nurse (LPN #3) included that the resident's NJ Ex Order 26, 4B1 . Resident does not have NJ Ex Order 26.4(b)(1). 1, NJ Ex Or evaluation completed." The Progress Notes did not include any documentation that the resident NJ Ex Order 26, 4B1 During an interview with LPN #1 on 10/27/2025 at 11:19 AM, she stated that at NJ Ex Order 26, 4B1, the resident was NJ Ex Order 26, 4B1 . LPN #1 stated that the assigned nurse (LPN #3) gave her the keys to LPN #3's medication cart because LPN #3 was going on break. LPN #1 stated that Resident #2 NJ Ex Order 26, 4B1 and she was going to give the resident NJ Ex Order 26, . LPN #1 stated when she went to Resident #2's room, the resident NJ Ex O . LPN #1 stated that she checked the hallway and did not find the resident, so she paged all staff to come to the NJ Ex O -Floor nursing unit. LPN #1 stated that as staff came, VF #1 of a different resident told her that they just saw a [gender retracted] NJ Ex Order 26 . LPN #1 stated that she, along with the other staff members, NJ Ex Order 26.4(b)(1) for about 1-2 minutes, and there was VF #2 NJ Ex Order 26, 4B1 on the facility's property that told them that the resident NJ Ex Order 26, 4B1 . LPN #1 stated that they NJ Ex Order 2 the resident NJ Ex Order 26, 4B1 standing on the sidewalk with NJ Ex Order 26, 4B1 " with NJ Ex Order 26, 4B1. LPN #1 stated that the resident NJ Ex O and the assigned nurse (LPN #3) assessed the resident and there were NJ Ex During an interview on 10/27/2025 at 5:04 PM, with the U.S. FOIA (b) (6)), the surveyor asked what should be documented in	F0658		

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F0658 SS = D	Continued from page 4 the resident's medical record in accordance with professional standards of practice. The[U.S. FOIA] stated falls, wounds, changes in status, medication changes, appointments, and behaviors. The surveyor asked if an [NJ Ex Order 26, 4B1] was considered[NJ Ex Order 26.4(b)(1], the[U.S. FOI] confirmed it would be and "technically" should have been documented in the resident's medical record. During a follow-up interview on 10/29/2025 at 12:06 PM, LPN #1 stated that the assigned nurse (LPN #3) had stepped away for five minutes and it was her responsibility to document Resident #2's[NJ Ex Order 26, 4B1] [NJ Ex Order 26]. LPN #1 confirmed that there should have been a Progress Note that included the resident's[NJ Ex Order 26, 4B1] on[NJ Ex Order 26, 4B1], so other staff were aware the resident had[NJ Ex Order 26] LPN #1 stated that charting was usually done on post incidents, and that this was an incident that should have been documented. On 10/29/2025 at 12:56 PM, the surveyor attempted to conduct a telephone interview with LPN #3, who did not answer. LPN #3 did not return the surveyor's telephone call, and she was not present during the survey for an interview. A review of the facility's policy titled "Nursing Documentation" dated 5/01/2025, included Purpose: "This policy is to establish guidelines and procedures for nursing documentation ..... to ensure accurate, timely and legally compliant documentation practices. Proper documentation provides a clear, consistent record of care, facilitates communication among care team members, and ensures continuity of care for residents." Policy Statement General Guidelines included: “1. Accuracy: All nursing documentation must be factual, accurate, and free from abbreviations that could cause confusion…... 2. Timeliness: Documentation should occur promptly after ……. Or receiving new information. Consistency: Documentation should be consistent across all records, ensuring that data is cohesive and easily understood by the entire team.” The same policy under “Documentation Requirements” included: “3. Documentation: Document all nursing interventions and observations, including but not limited to: ….. changes in condition or behavior. 4. Nursing Notes: Write concise, chronological notes on the resident status, interventions, and outcomes.” NJAC 8:39-27.1 (a)	F0658		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices	F0689	Corrective Action for the Affected Resident	11/20/2025

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F0689 SS = SQC-J	Continued from page 5 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Complaint #: 2650138 Based on observation, interviews, review of medical records, and review of other pertinent facility documents on NJ Ex Order 26, 4B1, it was determined that the facility failed to provide adequate supervision to a NJ Ex Order 26, 4B1 resident (Resident #2) with a known history of NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 The deficient practice was identified for 1 of 4 residents reviewed for NJ Ex Order 26, 4B1 (Resident #2). On 10/19/2025 at approximately 2:30 PM, the Licensed Practical Nurse (LPN #1) noticed Resident #2 was not in their room, and she could not find the resident. LPN #1 initiated a search, and a visiting family (VF #1) of another resident stated that they NJ Ex Order 26, 4B1 [gender redacted] NJ Ex Order 26, 4B1 and LPN #1 and other staff NJ Ex Order 26, 4B1 for Resident #2. While outside the facility, VF #2, who was at the facility's NJ Ex Order 26, 4B1, directed the staff to NJ Ex Order 26, 4B1. LPN #1 stated during an interview with the surveyor on 10/27/2025, that the resident NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1. The resident NJ Ex Order 26, 4B1, assessed with NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. The facility's failure to provide adequate supervision to a NJ Ex Order 26, 4B1 resident who was at risk for NJ Ex Order 26, 4B1, placed Resident #2 as	F0689	Continued from page 5 Resident number 2 NJ Ex Order 26, 4B1. A NJ Ex Order 26, 4B1. Physician and family members were notified. The Director of Maintenance checked all doors, elevators and the NJ Ex Order 26, 4B1 and all were confirmed to be operational. Statements were collected from all of the staff involved. The resident was placed on NJ Ex IDT meeting held to review the event and plan corrective actions. Resident care plan reviewed and updated. Facility wide re-education initiated on NJ Ex Order 26.4(b)(protocol. Identification of Other Residents Who May Be Affected All residents at risk for elopement potentially affected by deficient practice. All residents identified as at risk for elopement were assessed on 10/19/2025. Each was verified to have a functional NJ Ex Order 26.4(b)(1) No additional residents were missing or harmed. Care plans for all elopement-risk residents were updated to include Neighborhood Watch List inclusion, updated supervision levels, and wanderguard checks each shift Systematic Changes to Prevent Reoccurrence • All NJ Ex Order 26.4(b)(1) devices in facility tested 10/19/2025 — all fully functional. • All exit doors, elevators, and perimeter points tested — all functional. • New daily audit implemented (Director of Maintenance or designee) for all alarms and non-resident area exits. • Elopement drills increased in frequency; next completed on 10/27/2025. • Facility-wide re-education on elopement protocol completed 10/19–10/21/2025. • QAPI Performance Improvement Plan (PIP) for Elopement initiated 10/19/2025. • Construction area safety audit completed 10/20/2025;	

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F0689 SS = SQC-J	Continued from page 6 well as all residents.NJ Ex Order 26, 4B1. This posed a likelihood of serious harm, injury, impairment, or death and resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Ex Order 26.4(b)(1) at approximately 2:30 PM, after Resident #2 was last seen by staff in the facility. The facility Administration was notified of the IJ on NJ Ex Order 26.4(b)(1) at 5:15 PM. The facility submitted an acceptable Removal Plan (RP) on NJ Ex Order 26.4(b)(1) at 12:30 PM. The survey team verified the implementation of the RP during the continuation of the on-site survey on NJ Ex Order 26.4(b)(1) The facility further failed to b.) ensure all staff were able to identify a resident (Resident #4) who was a wanderer to provide adequate supervision to prevent NJ Ex Order 26.4(b)(1) This deficient practice was identified for 1 of 4 residents reviewed for NJ Ex Order 26.4(b)((Resident #4). The evidence was as follows: Part A A review of the facility provided “Elopement Policy and Procedure" dated 6/1/2025, included "It is the intent of the facility to be aware of its resident's usual habits and locations as reasonably practicable... Procedure...9 d. “In the event that there is any doorway equipment malfunction, supervision of that area will be provided unless there is only one resident at risk in which case the assigned staff member will provide 1:1 or other frequency or observation to the resident as determined by the physician or supervisor ...” A review of the facility provided “Wanderguard Use Policy” dated 5/1/2025, included the facility will provide safe, resident-centered, and regulatory-compliant guidance for the electronic wander management systems (e.g. Wanderguard) to prevent elopement…” “Maintenance, Testing, and Security” 1. “Maintenance staff or vendor shall perform proof scheduled preventative maintenance and immediate repairs..” 2. Test system functionality per facility schedule and after any power outage, building work, or reported malfunction.”	F0689	Continued from page 6 exit points secured. • Admissions policy revised to review all referrals with history of elopement. • Neighborhood Watch List with resident photos updated 10/24/2025 and posted 10/27/2025. • CNA assignments updated to include photo and wanderguard identification for residents at risk. • Education on new elopement identification process completed 10/27/2025. Monitoring to Ensure Ongoing Compliance • Daily alarm audits by Director of Maintenance or designee for 14 days, then weekly thereafter. • DON/designee to review elopement assessments and wanderguard function logs weekly x 4 weeks. • QAPI Committee to review all elopement data monthly and maintain PIP until 100% compliance achieved. • All new hires to receive elopement training during onboarding. • Elopement drills to be conducted monthly and reviewed by Safety Committee.	

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F0689 SS = SQC-J	Continued from page 7 A review of the Facility Reportable Event (FRE) dated NJ Ex Order 26.4(b)(1), that the facility submitted to the New Jersey Department of Health (NJDOH), revealed that on NJ Ex Order 26, 4B1, Resident #2 was noted NJ Ex Order 26, 4B1 at approximately 2:30 PM. An NJ Ex Order 26.4(b)(protocol was initiated, and the NJ Ex Order 26 While the NJ Ex Order 26 was happening, a visiting family member (VF #1) [of another resident] stated that she saw a [gender redacted] NJ Ex Order 26, 4B1 The facility staff prompted a prioritized search outside of the facility and found Resident #2 in the company of a person who noticed the residen NJ Ex Order 26.4(b)(1). At approximately 2:45 PM, the resident NJ Ex Order 26, 4B1 and their NJ Ex Order 26, 4B1 was noted to be fully functional. A NJ Ex Order 26, 4B1 was completed, and NJ Ex Order 26, 4B1 were noted. At 3:00 PM, Resident #2's doctor and family were notified, and the resident was placed on NJ Ex Order 26.4(b)(1) A review of LPN #1's statement included that she saw Resident #2 at approximately 2:30 PM, NJ Ex Order 26, 4B1 the nurse's station, and at approximately 2:40 PM, she checked, and Resident #2 was not in their room. LPN #1 stated that she paged all staff to the NJ Ex Or -Floor and all staff arrived. LPN #1 further stated that she was informed there was a [gender redacted] walking outside. LPN #1 stated that she and the staff ran outside and found the resident NJ Ex Order 26, 4B1 . LPN #1 noted the resident's NJ Ex Order 26, 4B1 alarmed when the resident re-entered the building. During an interview with the U. S. FOIA (b) (2) on 10/27/25 at 10:36 AM, he stated that there were no cameras, and that he was not sure of the NJ Ex Order 26, 4B1 but he surmised that NJ Ex Order 26, 4B1 went down the hallway on the NJ Ex Or -Floor nursing unit, through the unzipped plastic construction dust barrier, then through the NJ Ex Order 26.4(b)(1) into the dining and therapy area that were closed for renovations, and out an NJ Ex Order 26.4(b)(1). The U. S. FOIA (stated that he surmised that was the route of exit since all other NJ Ex Order 26.4(b)(1) systems were functioning and the receptionist at the main entrance denied seeing Resident #2 NJ Ex Order 26, 4B1 . The U. S. FOIA (2 stated the NJ Ex Order 26.4(b)(1) pin pad at the NJ Ex Order 26.4(b) was not operational at that time, and the lights on the NJ Ex Order 26.4(b)(1) pin pad were off when Resident #2 NJ Ex Order 2	F0689		

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F0689 SS = SQC-J	Continued from page 8 At that time, the U. S. FOIA guided the surveyors through the now zipped plastic dust barrier, through the double doors, into the construction area and out the back door. While outside, the U. S. FOIA (b) took the surveyors to the right on a path that led to a courtyard with a gate that accessed the facility's front driveway. The U. S. FOIA stated that he thought Resident #2 NJ Ex Order 26, 4B1 and the facility had now secured that gate with a chain lock. When the U. S. FOIA was bringing the surveyors back into the building from the back exit door, the surveyor observed an opening approximately two-feet wide from the building to hedges. The U. S. FOIA stated that since the ground beneath the opening was uneven rocks, he did not assume the resident went that way. At that time, the surveyors and the U. S. FOIA went through the opening, which led to the back of the building and around the dumpster/loading area, to the front parking lot area. In that area, the surveyor observed a gazebo on top of a hill with a winding paved foot path to the right, that led the surveyors down a wooded hill area that had a fallen tree trunk blocking the path approximately half-way down to the sidewalk at the roadside. The U. S. FOIA (b) stated the tree trunk had fallen that past weekend and was not yet cleared. Towards the end of the path was a pond, and the path ended on a sidewalk adjacent to a four-lane highway. The surveyor asked the U. S. FOIA how far the facility was to the sidewalk, and the U. S. FOIA stated approximately the length of a "football field." During an interview with LPN #2, who identified himself as the U. S. FOIA (b) (2), on 10/27/2025 at 11:02 AM, he stated that on NJ Ex Order 26.4(b)(1) he observed Resident #2 for a while NJ Ex Order 26, 4B1 of the residents' rooms, and NJ Ex Order 26, 4B1 LPN #2 stated that he assessed Resident #2 as an NJ Ex Order 26, 4B1 and placed a NJ Ex Order 26, 4B1 the resident. During an interview with LPN #1 on 10/27/2025 at 11:19 AM, she stated that at approximately 2:30 PM, the resident was walking around back and forth by the nurse's station. LPN #1 stated that the assigned nurse (LPN #3) gave her the keys to LPN #3's medication cart because LPN #3 was going on break. LPN #1 stated that Resident #2 complained they had NJ Ex Order 26, 4B1, and she was going to give the resident NJ Ex Order 26, 4B1. LPN #1 stated	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 9 when she went to Resident #2's room, the resident [redacted]. LPN #1 stated that she [redacted], so she paged all staff to come to the [redacted] Floor nursing unit. LPN #1 stated that as staff came, VF #1 of a different resident told her that they just saw a [gender redacted] [redacted] LPN #1 stated that she, along with the other staff members, [redacted] VF #2 sitting by the gazebo on the facility's property that told them that the resident '[redacted]). LPN #1 stated that they [redacted] with [redacted] who stated that the resident looked [redacted] " [redacted]. LPN #1 stated that resident was [redacted] and the assigned nurse (LPN #3) assessed the resident and there [redacted]. During an interview with the [redacted] on 10/27/2025 at 11:54 AM, he stated that there was a malfunction on the [redacted] by the [redacted] in the therapy room construction area. The [redacted] stated that the [redacted] usually had a red and green light on, and when he got there, no lights were lit, and the power for the magnet lock was disconnected. The [redacted] stated that he extended the wire and tightened the screws to fix the pin pad connection. The [redacted] further stated that when Resident #2 [redacted] the alarm should have alarmed to notify the nurses at the nurse's station that someone with a [redacted] exited. The [redacted] stated that he checked all the [redacted] and elevators daily on Monday through Friday, and the [redacted] checked them on Saturdays and Sundays. The [redacted] stated on the day of the [redacted] the [redacted] had not yet checked the alarms, so he had checked the alarms that day when the [redacted] arrived after the [redacted]. During interview with the [redacted] on 10/27/2025 at 2:11 PM, he confirmed he was the [redacted] on [redacted]. The [redacted] stated that on [redacted], he was busy that day and did not get to check the door prior to Resident #2 [redacted]. The surveyor reviewed the medical record for Resident #2. According to the Admission Record face sheet, Resident #2 was admitted to the facility with diagnosis which	F0689		

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F0689 SS = SQC-J	Continued from page 10 included but were not limited to; NJ Ex Order 26, 4B1 [redacted] According to the comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Ex Order 26, 4B1 Resident #2 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Or [redacted], which indicated the resident's NJ Ex Order 26, 4B1 [redacted] A review of Resident #2's NJ Ex Order 26, 4B1 Evaluation dated NJ Ex Order 26, 4B1 , included that Resident #2 NJ Ex Order 26, 4B1 [redacted], and NJ Ex Order 26, 4B1 likely to effect the safety or well-being of self/others." Resident #2 scored NJ Ex [redacted] and a score of [redacted] or higher indicated a NJ Ex Order 26, 4B1 on the assessment. A review of Resident #2's Care Plan (CP) with an initiated date of NJ Ex Order 26, 4B1, included that Resident #2 had the NJ Ex Order 26, 4B1 related to (r/t) NJ Ex Order 26, 4B1 The CP also indicated that Resident #2 had a NJ Ex Order 26, 4B1 on the resident's NJ Ex Order 26, [redacted] and that the resident should be NJ Ex Order 26, 4B1 [redacted] A review of the Progress Note (PN) dated NJ Ex Order 26, 4B1 [redacted], with an effective date of NJ Ex Order 26, 4B1 PM, written by LPN #3, included, 'NJ Ex Order 26, 4B1 [redacted] The resident does not have an NJ Ex Order 26, 4B1 1. NJ Ex Or [redacted] evaluation completed." There was no documentation of Resident #2's NJ Ex Order 26, 4B1 [redacted] A review of the PN dated late entry on NJ Ex Order 26, 4B1 [redacted], with an effective date of NJ Ex Order 26, 4B1 [redacted] written by LPN #2, included, "Resident was noted to be NJ Ex Order 26, 4B1 [redacted], NJ Ex Order 26, 4B1 [redacted]. Resident NJ Ex Order 26, 4B1 [redacted]. Resident then proceeded to go to another resident's room and try to open the bathroom door. Resident noted to have NJ Ex Order 26, 4B1. NJ Ex Order 26, 4B1 reassessed and NJ Ex Order 26, 4B1." On 10/29/2025 at 12:56 PM, the surveyor attempted to conduct a telephone interview with LPN #3, who did not answer. LPN #3 did not return the surveyor's telephone call, and she was not present during the survey for an interview.	F0689		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 11 An acceptable Removal Plan (RP) was received on 12/28/2025 at 12:29 PM, indicating the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice including: on NJ Ex Order 26.4(b)(1), Resident #2 was NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 was functional, the resident was assessed with NJ Ex Order 26, 4B1 On NJ Ex Order 26.4(b)(1), the U. S. FI checked doors, elevators, and NJ Ex Order 26, 4B1 systems to confirm functional, and identified a possible exit in a non-residential area and secured with alarm. On NJ Ex Order 26.4(b)(1), the facility began an investigation, and NJ Ex Order 26, 4B1 were tested. On 10/27/2025, the "Neighborhood Watch" list with residents' photos was updated, an NJ Ex Order 26.4(b)(drill was conducted, Certified Nursing Aide (CNA) assignments were updated to include identification of residents at risk for NJ Ex Order 26.4(b)(1 and all staff were educated on NJ Ex Order 26.4(b)(process. The surveyor verified the implementation of the Removal Plan on-site on 10/29/2025, and determined the immediacy was removed as of 10/29/2025 at 2:00 PM. Part B On 10/27/2025 at 9:57 AM, the surveyor interviewed the U. S. FOIA (b) (2)), who identified herself as the unit manager for the NJ Ex Order 26, -Floor nursing unit. The U. S. FOIA (b stated that the facility used a “Neighborhood Watch” list that identified who was at risk for NJ Ex Order 26, 4B1 that was hung at the nurse’s station. At that time, the U. S. FOIA (b provided a list from the nurse’s station that included three residents (Resident #1, Resident #2, and Resident #3), who were NJ Ex Order 26, 4B1 . On 10/27/2025 at 10:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #2), who identified himself as the U. S. FOIA (b) (2). LPN #2 stated that there were no residents residing on the NJ Ex O -Floor nursing unit who were an NJ Ex Order 26, 4B1. At that time, the surveyor observed a “Neighborhood Watch” list hanging at the nurse’s station that included four residents (Resident #1, Resident #2, Resident #3, and Resident #4) with their room numbers. On 10/27/2025 at 10:55 AM, the surveyor observed Resident #4’s name was still listed on the name plate outside their assigned room.	F0689		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = SQC-J	Continued from page 12 On 10/27/2025 at 11:07 AM, the surveyor requested from the U. S. FOIA (b) (2) to test the three residents' NJ Ex Order 26 4B1 for function. At that time, the surveyor observed the U. S. FOIA select Resident #1, Resident #2, and Resident #3, and he tested their NJ Ex Order 26, 4B1, and they all functioned. The U. S. FOIA did not ask which three residents and did not mention any additional residents who may have NJ Ex Order 26, 4B1 including Resident #4. The surveyor reviewed the medical record for Resident #4. A review of the Admission Record face sheet revealed that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26, 4B1 A review of the Progress Notes included a Social Services note dated NJ Ex Order 26, 4B1, that the resident was admitted to the facility on [date redacted] from NJ Ex Order 26, 4B1. The resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B1, [NJ Ex Order 26, 4B1. The resident was NJ Ex Order 26, 4B1 An additional review of the Progress Notes included a Nurses Progress Note dated NJ Ex Order 26, 4B1 that the resident was noted with NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1. A NJ Ex Order 26, 4B1 was applied and the family was notified who was aware of NJ Ex Order 26, 4B1 and agreed to a room change. A review of the Order Listing Report included a physician's order dated NJ Ex Order 26, 4B1 for a NJ Ex Order 26, 4B1 to NJ Ex Order 26, 4, check placement every shift. A review of the Care Plan (CP) included a focus area dated NJ Ex Order 26, 4B1, that the resident was an NJ Ex Order 26, 4B1 risk with regards to NJ Ex Order 26, 4B1. Interventions included to engage resident in purposeful activity; identify NJ Ex Order 26, 4B1; provide care in NJ Ex Order 26, 4B1; provide reorientation to surroundings, environment; and resident to have NJ Ex Order 26, 4B1. On 10/27/2025 at 12:36 PM, the surveyor observed the "Neighborhood Watch" sign at the NJ Ex Order 26, -Floor nursing unit now included four residents (Resident #1, Resident #2, Resident #3, and Resident #4).	F0689		

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F0689 SS = SQC-J	Continued from page 13 On 10/27/2025 at 12:37 PM, the surveyor interviewed Resident #4's Certified Nursing Aide (CNA #1), who stated that Resident #4 was new to the unit and had [NJ Ex Order 26, 4B1] CNA #1 stated that the resident self-propelled in a wheelchair, and that he checked on the resident when he checked on Resident #4's roommate NJ Ex Order 26, 4B1. CNA #1 stated that Resident #4 was [NJ Ex Order 26, 4B1] and NJ Ex Order 26, 4B1. CNA #1 stated that the facility had three residents who [NJ Ex Order 26, 4B1] and named (Resident #1, Resident #2, and Resident #3). When asked how he was informed who was a [NJ Ex Order 26, 4B], CNA #1 stated that staff informed him. On 10/27/2025 at 12:52 PM, the surveyor interviewed LPN #4, who cared for Resident #4. LPN #4 confirmed Resident #4 self-propelled in their wheelchair and wore a NJ Ex Order 26, 4B1 that she checked every shift for placement. At that time, the surveyor observed Resident #4 lying bed. LPN #4 showed the surveyor the resident's NJ Ex Order 26, 4B1 that was on their [NJ Ex Order 26, 4B]. On 10/27/2025 at 1:00 PM, the surveyor re-interviewed the [U.S. FOIA (b)] who stated that the resident was moved up to the unit during the evening shift on Friday ([NJ Ex Order 26, 4B1], medical record indicated the resident was NJ Ex Order 26, 4B1). The [U.S. FOIA (b)] confirmed it would be important that both the staff and she were aware of all the residents who were wanderers. The [U.S. FOIA (b)] stated that during morning huddle, staff were made aware of who the residents that [NJ Ex Order 26, 4B] were. The [U.S. FOIA (b)] further stated that there was a new "Neighborhood Watch" sign that included all four residents at the nurse's station, but it was not hung earlier. At that time, the surveyor requested the [U.S. FOIA (b)] inform the [U.S. FOIA] that they wanted to test the function of Resident #4's [NJ Ex Order 26, 4B1] On 10/27/2025 at 1:19 PM, the [U.S. FOIA] tested Resident #4's NJ Ex Order 26, 4B1 for function. At that time, the surveyor asked the [U.S. FOIA] why he did not test Resident #4's [NJ Ex Order 26, 4B1] earlier, and the [U.S. FOIA] stated because the surveyor only requested three residents' NJ Ex Order 26, 4B1 tested. The surveyor stated that they did not specify which three residents so how did the [U.S. FOIA] determine which residents the surveyor wanted tested. The [U.S. FOIA] stated that it "slipped my mind" when asked for three, and I "forgot" there was a fourth. When the surveyor questioned the [U.S. FOIA] that he "forgot," the [U.S. FOIA] sated he did not "forget, I misremembered." The [U.S. FOIA] stated that there were originally three residents who [NJ Ex Order 26, 4B1] and Resident #4 was recently added.	F0689		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = SQC-J	Continued from page 14 On 10/27/2025 at 5:04 PM, the survey team met with the U.S. FOIA (b) (6) [redacted] stated that the nurses identified someone at risk for NJ Ex Order 26, 4B1 [redacted] and placed a NJ Ex Order 26, 4B1 on them. The U. S. FOI [redacted] continued that the U. S. FOIA (b) (2) t updated the facility's "Neighborhood Watch" list, and during morning meeting with the department heads, they were made aware of any changes. At that time, the surveyor informed the facility about their observation of the "Neighborhood Watch" list with three residents only and that staff were unaware Resident #4 was at risk for NJ Ex Order 26, 4B1 [redacted] NJAC 8:39-27.1 (a)	F0689		

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061614	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Complaint #: 182825, 182275,186012,2585839, 2650138 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. 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 the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		11/20/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint# 182825 Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 21 out of 21 day shifts reviewed. Findings Include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or	S0560	CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The facility actively seeks to hire CNAs, that all shifts are scheduled to comply with ratios, that any callouts or no-shows result in calls being made by the shift supervisor to fill the shift. Recruitment efforts by the facility to hire CNA's, direct nursing staff include the following: Aggressively running ads through various social media platforms; Utilization of employment application websites; and fostering partnerships with recruitment and employment agencies. No residents have been adversely affected by the deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All residents have the potential to be affected by this situation. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR Facility's Recruitment and Retention Strategies and	11/20/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061614	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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S0560	Continued from page 1 certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility as documented below: 1. For the week of Complaint staffing from 01/19/2025 to 01/25/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: 01/19/25 had 10 CNAs for 117 residents on the day shift, required at least 15 CNAs. 01/20/25 had 10 CNAs for 114 residents on the day shift, required at least 15 CNAs. 01/21/25 had 10 CNAs for 114 residents on the day shift, required at least 15 CNAs. 01/22/25 had 11 CNAs for 114 residents on the day shift, required at least 15 CNAs. 01/23/25 had 11 CNAs for 114 residents on the day shift, required at least 15 CNAs. 01/24/25 had 11 CNAs for 114 residents on the day shift, required at least 15 CNAs. 01/25/25 had 10 CNAs for 118 residents on the day shift, required at least 15 CNAs. 2. For the 2 weeks of Complaint staffing from 10/12/2025 to 10/25/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: 10/12/25 had 10 CNAs for 103 residents on the day	S0560	Continued from page 1 Efforts have been in progress, which include but are not limited to the following: Offer Sign on bonuses to attract staff Recruitment bonus to encourage referrals from current staff Offer daily and weekend bonuses to attract overtime or PRN staff shifts Regularly meet with Staff to boost morale Conduct Staff Appreciation programs and activities to promote Staff Retention Aggressively run ads in various social media platforms and employment application websites Flexible shifts and schedules Increased wages to be well above state minimum Working with C.N.A. schools to recruit new grads Contract with staffing agencies MONITORING OF CORRECTIVE ACTIONS The Director of Nursing or designee will provide weekly reports to the Administrator regarding all efforts made to try to comply with the State's Staffing Ratios. Reports will be submitted to the Corporate Director of Human Resources/Payroll.	

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(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
S0560	Continued from page 2 shift, required at least 13 CNAs. 10/13/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. 10/14/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. 10/15/25 had 11 CNAs for 103 residents on the day shift, required at least 13 CNAs. 10/16/25 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. 10/17/25 had 9 CNAs for 103 residents on the day shift, required at least 13 CNAs. 10/18/25 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. 10/19/25 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. 10/20/25 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. 10/21/25 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs. 10/22/25 had 10 CNAs for 101 residents on the day shift, required at least 13 CNAs. 10/23/25 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. 10/24/25 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. 10/25/25 had 9 CNAs for 101 residents on the day shift, required at least 13 CNAs.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An on-site revisit for the facility's Plan of Correction was conducted on 12/08/25 in relation to the 10/29/25 Complaint survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		12/08/2025

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 reverse for further 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.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061614	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/08/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments An on-site revisit for the facility's Plan of Correction was conducted on 12/08/2025 in relation to the 10/29/2025 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities.	S0000		12/08/2025

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