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 05/21/2026

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 #s NJ 2591779, 2707265, 2713977 STANDARD SURVEY: 5/17-5/21/26 CENSUS: 110 SAMPLE SIZE: 22+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F0000		05/22/2026
F0698 SS = E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to: a) complete pre and/or post [NJ Ex Order 26] assessments for 2 of 2 residents (Resident #11 and #96); and b) ensure timing of a resident's medication was adjusted to accommodate their [NJ Ex Order 26] schedule, for 1 of 2 residents (Resident #96) reviewed for [NJ Ex Order 26] services. This deficient practice was evidenced by the following: 1. On 5/17/26 at 10:50 AM, the surveyor observed Resident #96 resting in bed, with their eyes closed. There were no observed concerns. On 5/18/26 at 9:48 AM, the surveyor reviewed the	F0698	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #11's and Resident #96's [NJ Ex Order 26.4(b)(1)] were immediately assessed, and the timing of their medications in the electronic health record was reviewed and updated accordingly. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving hemodialysis have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. A comprehensive review of the [NJ Ex Order 26] care provided to Resident #11 and Resident #96 was completed. The Director of Nursing immediately provided education to all licensed nursing staff regarding the importance of completing and documenting	07/08/2026

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

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F0698 SS = E	Continued from page 1 electronic medical record (EMR) of Resident #96. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) A comprehensive Minimum Data Set (MDS) assessment, an assessment tool to facilitate the management of care, dated NJ Ex Order 2, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #96 scored NJ Ex out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) . A physician's order dated NJ Ex Order 26 indicated Resident #96 was scheduled for NJ Ex Order 26 on Monday, Wednesday, and Friday with a pickup time of NJ Ex Order A physician's order dated NJ Ex Order 26.4 indicated to give NJ Ex Order 26.4(b)(1)) one tablet by mouth one time a day for NJ Ex Order 26.4(b)(1) The medication was scheduled to be given at 5 PM. A physician's order dated NJ Ex Order indicated NJ Ex Order 26.4(b)(1) one tablet by mouth three times a day for NJ Ex Order 26.4(b)(1) and hold for NJ Ex Order 26.4(b)(1)) greater than NJ Ex Ord The medication was scheduled to be given at 9:30 AM, 1:30 PM, and 5:30 PM. On 5/18/26 at 10:47 AM, the surveyor interviewed a U.S. FOIA (b)(6) assigned to care for Resident #96 about NJ Ex Order 26 care. The U.S. FOI stated that prior to sending a resident to NJ Ex Order 26.4 the nurse would check: the NJ Ex Order 26.4(b)(1); the resident's vital signs (VS; blood pressure, heart rate, temperature, and respiratory rate); check the resident's overall status; and administer medications as ordered by the physician. The U.S. FOI further explained that a binder was sent with a NJ Ex Order 26 communication form for each session. The top portion of the form was completed by the sending nurse at the facility, and the bottom portion was completed by the NJ Ex Order 26 center. The surveyor asked the U.S. FOI about post-dialysis documentation upon the resident's return to the facility. The U.S. FOI replied that a progress note should	F0698	Continued from page 1 comprehensive pre- and post-dialysis assessments. The education included instruction on the revised Dialysis Communication Form and the requirements for obtaining and documenting all vital signs, assessing dialysis access site integrity, and evaluating the resident's overall clinical condition before and after each dialysis treatment. The Director of Nursing reviewed Resident #96's physician orders and medication administration schedule. The electronic medication administration record was updated to ensure medication administration times accurately reflect the resident's dialysis treatment schedule. Unit Managers or designee will perform monitoring of pre- and post-dialysis assessment and medication administration documentation three times a week to verify timely and complete completion by licensed nursing staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing or designee, will conduct documentation and medication administration audits of all residents on hemodialysis twice weekly for two weeks, followed once weekly for an additional two weeks. Audit findings will be presented by the Director of Nursing to the Quality Assurance Committee during the monthly QAPI meeting to evaluate compliance and determine if further action is needed to ensure 100% compliance.	07/08/2026

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F0698 SS = E	Continued from page 2 be documented in the EMR about their overall status and VS checked. The [U.S. FOI] stated a resident's medication should be timed around their [NJ Ex Order 26] session. On 5/18/26 at 10:55 AM, the surveyor observed Resident #96 in their room, alert and verbally responsive. Resident #96 confirmed they go to [NJ Ex Order 26] every Monday, Wednesday, and Friday. Resident #96 had no concerns with their care. Resident #96 stated they returned from the [NJ Ex Order 26] center to the facility around 6 to 7 PM. On 5/18/26 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b)(6) about dialysis care. The [U.S. FOIA (b)(6)] stated a resident's medication should be timed around their [NJ Ex Order 26] session. The surveyor asked the [U.S. FOIA (b)(6)] when Resident #96 usually returned from [NJ Ex Order 26.4] The [U.S. FOIA (b)(6)] replied around 7 PM. The surveyor informed the [U.S. FOIA (b)(6)] of concerns for medications timed around 5 PM as the resident would be in [NJ Ex Order 26] during the medication administration timeframe. The [U.S. FOIA (b)(6)] provided the surveyor with Resident #96's [NJ Ex Order 26] communication binder. The binder included [NJ Ex Order 26] communication forms which had two sections. The first section was to be completed by the nurse prior to sending the resident to [NJ Ex Order 26.4] [NJ Ex Order 26] The second section was completed by the center nurse. The [U.S. FOIA (b)(6)] stated that upon a resident's return from the [NJ Ex Order 26.4] the nurses were to assess the resident, check their VS, and write a note in the EMR. The [U.S. FOIA (b)(6)] and the surveyor reviewed the progress notes in the EMR. There were two progress notes dated [NJ Ex Order 26] and [NJ Ex Order 26] which documented the resident's [NJ Ex Order 26.4(b)(1)] assessment and return from [NJ Ex Order 26.4] Additionally, the [NJ Ex Order 26.4] progress note indicated the resident returned from [NJ Ex Order 26] around 8 PM. The [U.S. FOIA (b)(6)] stated the nurses should be documenting [NJ Ex Order 26.4(b)(1)] assessments and the timing of medications would be reviewed. On 5/19/26 at 1:12 PM, the surveyor informed the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) about the concerns of no [NJ Ex Order 26.4(b)(1)] assessments documentation for Resident #96 and medication scheduled when the resident would be at [NJ Ex Order 26] session. On 5/20/26 at 11:02 AM, the [U.S. FOIA] and the [U.S. FOIA (b)] met with the survey team. The [U.S. FOIA] stated education was being provided to staff about [NJ Ex Order 26] assessment completion and timing of medication	F0698		07/08/2026

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F0698 SS = E	Continued from page 3 administration. The [U.S. FOIA] added, all [NJ Ex Order 26] residents' EMR were being audited. There was no additional information provided by the facility. The surveyor reviewed the undated facility provided policy titled "Administering Medications" which revealed under Policy Statement: "Medications are administered in a safe and timely manner, and as prescribed." Under Policy Interpretation and Implementation of the policy revealed: 4. Medications are administered in accordance with prescriber orders, including any required timeframe. 7. Medications are administered within one hour of their prescribed time, unless otherwise specified. The surveyor reviewed the facility provided policy titled "Dialysis/ESRD Care" dated 5/1/25 which revealed under Policy Statement: Dialysis services will be provided in accordance with physician orders and industry best practices to ensure the safety, comfort, and well-being of residents. The policy did not further address documentation of dialysis resident assessments; and the timing of medication administration for dialysis residents. A review of the electronic medical record revealed the following information. The Admission Record indicated the resident was admitted dependent on [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)] The Order Summary Report contained a physician's order for hemodialysis three times a week at 6 AM. The [NJ Ex Order 26.4(b)(1)] was noted to be [NJ Ex Order 26.4(b)] a [NJ Ex Order 26.4(b)(1)]. On 5/18/26 at 10:25 AM, the surveyor interviewed the [U.S. FOIA (b)(6)]) who stated the [NJ Ex Order 26.4(b)(1)] and vital signs should be assessed when the resident leaves for [NJ Ex Order 26] and when they return. The assessment should be documented in the electronic nursing progress notes. This was confirmed by the [U.S. FOIA (b)(6)]) on 5/18/26 at 12:25 PM. Nursing documentation in electronic Skilled Nursing Progress Notes during [NJ Ex Or] and [NJ Ex O] failed to reveal consistent assessment [NJ Ex Order 26.4(b)(1)].	F0698		07/08/2026

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F0698 SS = E	Continued from page 4 The Dialysis Communication report, a one-page form accompanying the resident to the dialysis clinic, was also inconsistently filled out – often containing only a blood pressure. The dialysis care plan initiated NJ Ex Order 26.4(and revised NJ Ex Order 26 contained interventions to monitor vital signs and the NJ Ex Order 26.4(b)(1) however, it did not address NJ Ex Order 26.4(b)(1) assessments. The Dialysis/End Stage Renal Disease Policy and Procedure, dated 5/1/25, indicated residents receiving dialysis will be closely monitored, although, it did not address pre and post dialysis assessment of vital signs and dialysis access site integrity. On 5/20/26 at 11:00 AM, the U.S. FOIA (b) stated all nurses were reeducated to perform NJ Ex Order 26.4(b)(1) assessments. NJAC 8:39-2.9, 27.1 (a)	F0698		07/08/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F0880	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were adversely affected by this practice. Laundry Docking Area: On 05/22/2026, all isolation linens, clothing, laundry detergent supplies, wheelchairs, and other resident care equipment were immediately removed from the outdoor docking area. The damaged awning was repaired on 05/25/26. The entire docking area was thoroughly power washed and sanitized on 05/26/2026. The soiled brown plastic curtains located at the entrance to the dock ramp were replaced on 05/24/26. Laundry Room Equipment Storage: On 05/22/2026, all equipment stored in the laundry room, was removed from the area. The items were thoroughly cleaned and disinfected, then relocated to designated clean storage areas. All equipment maintained in protective plastic coverings and stored in appropriate clean locations, separate from cleaning chemicals and protected from dust and other potential contamination sources. Clean Linen and Equipment Storage: On 05/22/2026, all clean white linens and a wheelchair cushion observed stored on open shelving near the dryers and folding area were immediately removed	07/10/2026

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F0880 SS = E	Continued from page 5 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to follow appropriate infection control practices for: a)	F0880	Continued from page 5 from service. These items were either re-laundered or cleaned and disinfected, then properly stored in designated clean storage areas in protective plastic coverings. The two fans with visible black debris and broken components were removed from service on 05/22/2026. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Environmental Services Director and designee completed a comprehensive audit of linen and equipment storage. All used equipment was appropriately cleaned, disinfected, and stored in accordance with facility policy and procedures. An additional storage area was identified and designated to accommodate unused linens and equipment to ensure proper organization and reduce risk of contamination. The Housekeeping Department implemented a daily cleaning schedule along with ongoing monitoring of the laundry docking area, laundry room, and equipment storage areas to maintain a safe and sanitary environment. The Director of Nursing immediately provided education to certified nursing assistants regarding the proper handling and distribution of residents' personal items during care activities. The Infection Preventionist Nurse provided education to all staff on the facility's Infection Prevention and Control policy, including appropriate cleaning of storage areas, proper disinfection and storage of equipment, storage of clean linens, and correct handling of residents' personal items or belongings. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change.	07/10/2026

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F0880 SS = E	Continued from page 6 personal protective equipment (PPE) use while performing high contact care in an [NJ Ex Order 26.4(b)(1)]) room for 1 of 1 [U.S. FOIA (b)(6)] observed on 1 of 2 units; b) handling of personal care items for a resident for 1 of 1 [U.S. FOIA] observed on 1 of 2 units; and c) storage of medical equipment and linens to decrease the possibility of spreading infection during a tour of the laundry area. 2. On 5/20/26 at 10:37 AM, the surveyor toured the laundry area with the [U.S. FOIA (b)(6)]), who stated that the facility collected the soiled laundry every 2 hours from units and they used two containers in soiled utility rooms. One container was for soiled linens and another for garbage. The surveyor observed that the isolation linens and clothing for resident's was kept outside in the docking area. There were multiple items being stored there, including full laundry detergent items, wheelchairs and other resident equipment. There was an awning covering the outside area, yet a large portion of the awning was missing and the items below it were wet with rainwater. Additionally, the surveyor observed plastic curtains leading up to the dock ramp, which were soiled with a brown coloration and was observed to be wet as well. The [U.S. FOIA] stated that the area needed to be washed and the facility would use a power washer to clean the area except that the power washer was not working at the moment. The [U.S. FOIA] stated that the docking area is not the best place to store items and the awning needed to be repaired. In the laundry room, the surveyor observed storage of equipment, and some of the equipment was open to the air, including bedside commode chairs, mattress, wedge pillows next to boxes of cleaning products. The [U.S. FOIA] picked up an item form the shelf and dust like particles came off of the item. The [U.S. FOIA] stated that there is limited storage space and the items should be clean and acknowledged that some items stored there need to be cleaned. In the laundry room, near the dryers and the folding area, the surveyor observed shelves with extra equipment stored on the shelves. Several items were also not stored in plastic bags, including white cleaned linens and a wheelchair cushion, which was open to the air. The wheelchair cushion was observed to be covered with dust-like particles. There were two fans in use, which had black colored debris on them and the fans both had broken pieces hanging off of them. The [U.S. FOIA] stated that these items are all cleaned and should be stored in bags.	F0880	Continued from page 6 The Environmental Services Director will conduct daily rounds and audits to assess the cleanliness and organization of the laundry docking area, laundry room, and storage areas five (5) days per week for two (2) weeks. This will be followed by monitoring three (3) times per week for an additional two (2) weeks to ensure continued compliance with facility standards. The Infection Preventionist Nurse will conduct audits of five (5) certified nursing assistants during the handling of residents' personal items while providing care, two to three (2–3) times weekly for four (4) weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance	07/10/2026

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F0880 SS = E	Continued from page 7 On 5/21/26 at 1:24 PM, the surveyor discussed the above concerns with the U.S. FOIA (b)(6) No further information was provided. N.J.A.C. 8:39-19.4 2. On 5/20/26 at 10:37 AM, the surveyor toured the laundry area with the U.S. FOIA (b)(6)), who stated that the facility collected the soiled laundry every 2 hours from units and they used two containers in soiled utility rooms. One container was for soiled linens and another for garbage. The surveyor observed that the isolation linens and clothing for resident's was kept outside in the docking area. There were multiple items being stored there, including full laundry detergent items, wheelchairs and other resident equipment. There was an awning covering the outside area, yet a large portion of the awning was missing and the items below it were wet with rainwater. Additionally, the surveyor observed plastic curtains leading up to the dock ramp, which were soiled with a brown coloration and was observed to be wet as well. The U.S. FOI stated that the area needed to be washed and the facility would use a power washer to clean the area except that the power washer was not working at the moment. The U.S. FOI stated that the docking area is not the best place to store items and the awning needed to be repaired. In the laundry room, the surveyor observed storage of equipment, and some of the equipment was open to the air, including bedside commode chairs, mattress, wedge pillows next to boxes of cleaning products. The U.S. FOI picked up an item form the shelf and dust like particles came off of the item. The U.S. FOI stated that there is limited storage space and the items should be clean and acknowledged that some items stored there need to be cleaned. In the laundry room, near the dryers and the folding area, the surveyor observed shelves with extra equipment stored on the shelves. Several items were also not stored in plastic bags, including white cleaned linens and a wheelchair cushion, which was open to the air. The wheelchair cushion was observed to be covered with dust-like particles. There were two fans in use, which had black colored debris on them and the fans both had broken pieces hanging off of them. The U.S. FOI stated that these items are all cleaned and should be stored in bags. On 5/21/26 at 1:24 PM, the surveyor discussed the above concerns with the U.S. FOIA (b)(6) No further	F0880		07/10/2026

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F0880 SS = E	Continued from page 8 information was provided.	F0880		07/10/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Repeat Deficiency Based on observation, interview, and record review, it was determined that the facility failed to ensure the resident's call device was readily accessible. The deficient practice was identified for 5 of the 22 residents (Resident #2, 15, 33, 67, and #92) reviewed for reasonable accommodations of needs/preferences. This deficient practice was evidenced by the following: 1. On 5/17/26 at 9:54 AM, the surveyor observed Resident #2 in bed asleep. The surveyor observed that the resident's call device was wrapped around the resident's [NJ Ex Order 26.4(b)(1)], almost touching the floor. On 5/18/26 at 8:58 AM, the surveyor observed that Resident #2 was awake, and the call device was wrapped around the resident's [NJ Ex Order 26.4], almost touching the floor. Resident #2 stated that they don't know where the call device is. The surveyor asked the resident if they were able to reach the call device. Resident #2 stated that they cannot reach it. On 5/18/26 9:04 AM, the surveyor, together with the [U.S. FOIA (b)(6)] went to Resident #2, and the [U.S. FO] observed that the resident's call device was wrapped around the [NJ Ex Order 26.4(] and almost touching the floor. The [U.S. FO] stated that it should be within the resident's reach. On 5/18/26 at 10:25 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #2, which	F0558	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #2's call light was immediately repositioned within the resident's reach and secured to prevent displacement. Resident #15's call light was immediately repositioned within reach, and the [NJ Ex Order 26] water bottle was replaced. Resident #33's call light was immediately retrieved from the floor and placed within the resident's reach. Resident #67's call light was immediately removed from the [NJ Ex Order 26.4(] and repositioned appropriately within the resident's reach. Resident #92's call light was immediately unwrapped from the [NJ Ex Order 26.4(b)(1)] and repositioned within reach on the resident's [NJ Ex Order 26.] , consistent with the resident's [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)]. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Administrator provided education to all staff participating in Ambassador Rounds to ensure that residents' call lights are properly secured, within reach, and positioned in accordance with each resident's individual positioning needs and preferences. The Director of Nursing provided education to all staff regarding the facility Call Light Policy. This education emphasized the importance of verifying appropriate call light placement, securement, and accessibility during routine rounds and prior to exiting a resident's room after delivering care. The Call Light Audit Form was revised to include monitoring of call light response times, as well as	07/08/2026

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 05/21/2026

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
F0558 SS = D	Continued from page 9 revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #2 was admitted with diagnoses that included but were not limited to [redacted]. A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) o[redacted] indicated that the facility assessed the residents' [redacted] status using a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that the resident had [redacted]. Further review of Q/MDS, as reflected in Section [redacted] revealed that Resident #2 was [redacted] on staff assistance with the activities of daily living (ADL). A review of the Care Plan (CP) report initiated on [redacted] that focused on Resident #2 is at risk for [redacted] related to [redacted], use of [redacted] medication, and multiple medical conditions. Interventions included, but were not limited to, ensuring the resident's call light is within reach and encouraging the resident to use it for assistance as needed. 2. On 5/17/26 at 9:52 AM, the surveyor observed Resident #15 asleep in bed with [redacted] attached to the [redacted]). It was observed that the water in the plastic bottle attached to the [redacted] was almost empty. The surveyor observed that the resident's call device was wrapped around the [redacted] and almost touching the floor. On 5/18/26 at 10:25 AM, the surveyor reviewed the eMR of Resident #15, which revealed the following: A review of the AR reflected that Resident #15 was admitted with diagnoses that included but were not limited to [redacted] and [redacted] following [redacted]	F0558	Continued from page 9 documentation of proper securement, placement, and accessibility within the resident's reach. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing and Unit Managers will conduct audits of call light placement for ten residents on each floor three times per week for two weeks, followed by two times per week for an additional two weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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F0558 SS = D	Continued from page 10 A review of the recent Q/MDS o[NJ Ex Order 26.4] indicated that the facility assessed the residents' [NJ Ex Order 26.4(] status using a BIMS score [NJ E] 0 out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1) [redacted]. Further review of Q/MDS, as reflected in Section [NJ Ex Order 26.4(b)(1)] revealed that Resident #15 was [NJ Ex Order 26.4(b)(1] on staff assistance with the ADL. A review of the CP report initiated on [NJ Ex Order 2] focused on Resident #15, who is at risk for [NJ Ex O] related to NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)(1] and at risk of an ADL NJ Ex Order 26.4(b)(1) deficit related to [NJ Ex Order 26.4(b)(1] Interventions included, but were not limited to, ensuring the resident's call light is within reach and encouraging the resident to use it for assistance as needed. 3. 05/18/2026 at 9:09 AM, the surveyor observed Resident #33 asleep in bed. The surveyor observed that the resident's call device was lying on the floor, located to the [NJ Ex Order 26] of the resident. On 5/18/26 9:10 AM, the surveyor, together with the U.S. FOIA (b)(6) [redacted]), went to the residents' room to observe the call device. The [U.S. FOIA (b)(6)] picks up the call device from the floor and puts it within the residents' reach. On 5/18/26 at 10:40 AM, the surveyor reviewed the eMR of Resident #33, which revealed the following: A review of the AR reflected that Resident #33 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), [redacted] NJ Ex Order 26.4(b)(1), and anxiety. A review of the annual Minimum Data Set (A/MDS) of 4/17/26 indicated that the facility assessed the residents' [NJ Ex Order 26.4(] status using a BIMS score of [NJ] out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1). Further review of A/MDS, as reflected in Section [NJ Ex Order 26.4(b)(1)] [redacted] assistance with the ADL. A review of the CP report initiated on [NJ Ex Order 26]	F0558		07/08/2026

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F0558 SS = D	Continued from page 11 focused on Resident #33, who is at risk of [redacted] related to balance problems. Interventions included, but were not limited to, ensuring the resident's call light is within reach and encouraging the resident to use it for assistance as needed. 4. On 5/17/26 at 9:52 AM, the surveyor observed Resident #67 in bed, awake, unable to answer the surveyor's inquiry. The surveyor observed that the resident's call device was wrapped around the [redacted] the floor. On 5/18/26 at 8:54 AM, the surveyor reviewed the eMR of Resident #67, which revealed the following: A review of the AR reflected that Resident #67 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) and [redacted]. A review of the significant change Minimum Data Set (SC/MDS) of [redacted] indicated that the facility assessed the residents' cognitive status using a BIMS score of [redacted] out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1). Further review of SC/MDS, as reflected in Section [redacted], revealed that Resident #67 was [redacted] on staff assistance with the ADL. A review of the CP report initiated on [redacted] focused on Resident #67, who is at risk for [redacted] related to NJ Ex Order 26.4(b)(1). Interventions included, but were not limited to, ensuring the resident's call light is within reach and encouraging the resident to use it for assistance as needed. 5. On 5/18/26 at 9:09 AM, the surveyor observed Resident #92 awake, sitting at the edge of the bed on the [redacted]. The surveyor observed that Resident #92's call device was wrapped around the [redacted], almost touching the floor. On 5/18/26 at 9:10 AM, the surveyor, together with the [redacted], went to the resident's room. The [redacted] unwrapped the call device from the [redacted] and put it within the resident's reach.	F0558		07/08/2026

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F0558 SS = D	Continued from page 12 On 5/18/26 at 11:22 AM, the surveyor reviewed the eMR of Resident #92, which revealed the following: A review of the AR reflected that Resident #92 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26. A review of the A/MDS of NJ Ex Order indicated that the facility assessed the residents NJ Ex Order 26.4(status using a BIMS score of NJ out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1). Further review of A/MDS, as reflected in Section NJ Ex O, revealed that Resident #92 was NJ Ex Order 26.4(b)(1 on staff assistance with the ADL. A review of the CP report initiated on NJ Ex Order 2 that focused on Resident #92 is at risk for NJ Ex O related to gait NJ Ex Order 26.4(b)(1) and wandering, and at risk of an ADL NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b) initiated on NJ Ex Order 26 interventions included, but were not limited to, ensuring the resident's call light is within reach and encouraging the resident to use it for assistance as needed. On 5/18/26 at 9:00 AM, the surveyor interviewed a Certified Nursing Assistant (CNA), who stated that the call device should be within the resident's reach in case they need help from the staff. On 5/18/26 at 9:04 AM, the surveyor interviewed the U.S. FO who stated that the call device should be placed within the resident's reach. On 5/18/26 at 9:06 AM, the surveyor, together with the U.S. FOIA (b)(6) went to all the residents' rooms (Resident #2, 15, 33, 67, & 92). The U.S. FOIA (b)(6) stated that the call device should always be within the resident's reach. Reinforce the residents to use the call device if they need any assistance from the staff. On 5/19/26 at 1:40 PM, the team of surveyors met with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) regarding the concern above, but did not provide further information.	F0558		07/08/2026

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F0558 SS = D	Continued from page 13 A review of the facility's policy titled "Answering the Call Light," with the revision date of September 2022, stated under "General Guidelines 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility, and from the floor." NJAC 8:39-31.8(c)9	F0558		07/08/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels.	F0584	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #5's soiled utility pole was removed from service on 05/20/2026. The NJ Ex Order 26.4(b)(1) was cleaned, disinfected, and appropriately covered with a protective plastic bag. The three-foot section of damaged baseboard cove base was replaced on 05/22/2026. The 12-inch long by 2-inch high hole in the sheetrock was repaired, sanded, and repainted on 05/23/2026. Room #214's torn wallpaper with a loose flap in the bathroom above the sink was removed. The area was properly prepared and repainted on 05/24/2026. The two-foot section of missing cove base molding in the bathroom was replaced, and damaged sheetrock to the right of the toilet was repaired and repainted on 05/25/2026. The 6-inch by 12-inch torn wallpaper flap on the wall behind the window bed was removed, and the area was properly finished on 5/26/2026. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Administrator implemented a weekly rounding schedule with the Maintenance Director to inspect	07/08/2026

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F0584 SS = D	Continued from page 14 Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to maintain a homelike environment. Specifically, the facility failed to: a) keep the facility's environment in an adequate state of repair on 1 of 2 nursing care units surveyed, and b) failed to clean and maintain the equipment for 1 of 22 residents (Resident #5) reviewed for homelike environment. The deficient practice was evidenced by the following: On 5/17/26 at 10:17 AM, during an initial tour of [NJ Ex O] floor nursing care unit the surveyor observed a two foot wide by two foot long area of damaged sheet rock and a large torn flap of wallpaper next to the door bed in room [NJ Ex Or]. The [NJ Ex Order 26.4(b)] and the NJ Ex Order 26.4(b)(1) attached, for Resident #5, was observed to be soiled with spatters of light brown dried substance and large areas of dark brown to black areas of crusted dried substance and missing paint. On 5/17/26 at 10:35 AM, during an initial tour of 2nd floor nursing care unit the surveyor observed the following in room 214: A three foot long area of damaged baseboard cove base with a twelve inch long 2 inch high hole in the sheetrock, Torn wallpaper with a loose flap in the bathroom over the sink, 2 feet of missing cove base molding and damaged sheetrock in the bathroom to the right of the toilet and a six inch by twelve inch torn flap of wallpaper on the wall behind the window bed. On 5/18/26 at 10:10 AM the surveyor interviewed the U.S. FOIA (b)(6), a Registered Nurse (RN), the surveyor asked the [U.S. Fo] about the observed utility pole and soiled equipment in room [NJ Ex Order 26.4] and pump, soiled with dried brown substance splatters and crusty brown to black substance and missing paint on base. RN acknowledged the equipment should be kept clean and in good repair and the observed condition detracted from the facility's homelike environment. On 5/19/2026 at 12:30 PM, the surveyor interviewed	F0584	Continued from page 14 overall facility conditions and identify areas requiring repair or improvement. The Administrator provided education to the U.S. FOIA (b)(6) on the importance of preventive maintenance and assisted in developing a structured schedule for routine inspection and servicing of all medical equipment. Additionally, the Administrator and Maintenance Director established a formalized schedule for equipment cleaning and maintenance, along with clear criteria for identifying environmental deficiencies and defined protocols for prompt corrective action and repair response. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Maintenance Director will conduct weekly audits of items and equipment requiring maintenance or repair for four (4) weeks, followed by biweekly audits for an additional four (4) weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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F0584 SS = D	Continued from page 15 the U.S. FOIA (b)(6)). The surveyor reviewed the findings of the damage to walls in room [redacted] and room [redacted] The [redacted] acknowledged the areas are a detraction of from the facility's homelike environment On 5/19/26 at 1:10 PM, the surveyor and the survey team met with Licensed Nursing home administrator and the U.S. FOIA (b)(6) [redacted] and [redacted] to discuss concerns [redacted] and [redacted] acknowledged torn wallpaper, broken sheetrock, soiled pole and equipment observed in rooms [redacted] and [redacted] detracted from facility's homelike environment. A review of the facility provided policy titled Homelike Environment reflected … Residents are provided with a safe, clean, comfortable and homelike environment. NJAC 8:39-31.2(e)	F0584		07/08/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F0641	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #122 was discharged from the facility on [redacted] The assessment was immediately completed by the Vice President of Reimbursement on 5/19/2026. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Vice President of Reimbursement conducted a comprehensive audit of facility discharges submitted within the 90 days prior to the survey, and no additional coding discrepancies were identified. The Vice President of Reimbursement provided education to the U.S. FOIA (b)(6) regarding the importance of accurate discharge coding within MDS	07/08/2026

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F0641 SS = D	Continued from page 16 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 1 of 25 residents reviewed (Resident # 122). The deficient practice was evidenced by the following: The surveyor reviewed Resident # 122's records. The resident was discharged from the facility to the NJ Ex Order 26.4(b)(1) and according to the Discharge Return Not Anticipated MDS, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26, the resident was assessed as having an unplanned discharge to home/community. A review of Resident # 122's progress notes dated NJ Ex Order 26 revealed the resident was discharged to the ER. During an interview on 5/19/26 at 1:13 PM, the surveyor brought the above concerns to the attention of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6) NJAC 8:39-11.2(e)1	F0641	Continued from page 16 reporting. The Vice President of Reimbursement implemented a clinical review process for all discharges during the daily morning meeting to ensure accurate communication and oversight. The Director of Nursing and the MDS Coordinator established a weekly interdisciplinary meeting to cross-reference facility discharges with MDS assessments to ensure accurate coding prior to submission. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Vice President of Reimbursement will conduct an audit of all submitted MDS once week for four weeks, followed by every other week week for an additional four weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Repeat Deficiency	F0677	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #13's NJ Ex Order 26.4(b)(were immediately NJ Ex Order 26.4 and cleaned the NJ Ex Order 26.4(b)(1) was removed and proper NJ Ex O hygiene was restored 5/19/26. How the facility will identify other residents having the potential to be affected by the same deficient practice.	07/08/2026

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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
F0677 SS = D	Continued from page 17 Based on observation, interview, and review of the pertinent medical record, it was determined that the facility failed to ensure that necessary care was provided to a NJ Ex Order 26.4(b)(1) resident who required staff assistance for NJ Ex Order 26.4(b)(1) for 1 (one) of 4 sampled residents (Resident #13) reviewed for Activities of Daily Living (ADL). This deficient practice was evidenced by the following: On 5/17/26 at 10:01 AM, the surveyor observed Resident #13 lying in bed awake, able to answer the surveyor's inquiry. The surveyor observed that both residents' NJ Ex Order 26.4(b)(1) and there is NJ Ex Order 26.4 the NJ Ex Order 26.4(b)(1) On 5/19/26 at 10:30 AM, the surveyor and the U.S. FOIA (b)(6)) went to the resident's room to observe that Resident #13's NJ Ex Order 26.4(b)(were NJ Ex Ord and there was NJ Ex Order 26.4(b)(1) The resident stated they want the NJ Ex Order 26.4(b)(1 to be NJ Ex Order 26.4 by the staff. The U.S. FOIA (b)(stated that the nurses usually NJ Ex O the NJ Ex Order 26.4(b)(1) and he will get the nurse's attention regarding the concern above. On 5/19/25 at 9:31 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #13, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #13 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26. A review of the recent quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) of NJ Ex Order 26 indicated that the facility assessed the residents NJ Ex Order 26.4(status using a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1). Further review of Q/MDS, as reflected in Section NJ Ex Orde revealed that Resident #13 was NJ Ex Order 26.4(b)(1 on staff assistance with the ADL.	F0677	Continued from page 17 All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing provided education to licensed nursing staff and certified nursing assistants regarding the facility's Activities of Daily Living (ADL) policy, with specific emphasis on the importance of appropriate nail care. The Unit managers on each floor were the designated primary staff responsible for ensuring residents' nails are trimmed and clean. Unit Managers developed a structured rounding schedule along with an audit tool for their assigned units. The audit includes monitoring of nail length, cleanliness, and overall nail health to ensure compliance with facility standards and resident care expectations. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Unit Managers will conduct audits of ten residents nail length and cleanliness twice weekly for two weeks, followed by audits of ten residents once weekly for an additional two weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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 05/21/2026

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
F0677 SS = D	Continued from page 18 A review of the Care Plan (CP) report initiated on [NJ Ex Order 26] that focuses on Resident #13 has an ADL [NJ Ex Order 26.4(b)(1)] related to [NJ Ex Order 26.4(b)(1)], and [NJ Ex Order 26.4(b)(1)]. Interventions included, but were not limited to, checking [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4] and [NJ Ex Order 26.4] on bath day and as necessary. On 5/19/26 at 1:40 PM, the team of surveyors met with the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] regarding the concern above, but did not provide further information. A review of the facility's policy title "Activities of Daily Living (ADLs), Supporting", with a revised date on April 2025, revealed under "Policy Statement: Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal hygiene." A review of the facility policy title "Quality of Life - Dignity" stated under "Policy Interpretation and Implementation 3. a. Personal grooming - residents are groomed as they wish to be groomed (hair styles, nails, facial hair, etc.)." NJAC 8:39-27.2(g)	F0677		07/08/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices 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: Based on observation, interview, and record review,	F0689	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #10 in Room [NJ Ex O]'s loose grab bar in the bathroom was immediately secured and reinforced by the Maintenance Director on 05/19/2026. The grab bar was subsequently tested to ensure stability and appropriate weight-bearing capacity. Resident #28 in Room [NJ Ex O] unopened [NJ Ex Order 26.4(b)(1)] was immediately discarded. A medication reconciliation was completed, and review of Resident #28's medication orders confirmed that [NJ Ex Order 26.4(b)(1)] had been discontinued on 05/05/2026. How the facility will identify other residents having	07/08/2026

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 05/21/2026

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE , WAYNE, New Jersey, 07470

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F0689 SS = D	Continued from page 19 it was determined that the facility failed to ensure the facility remained free of accident hazards. The deficient practice was identified for 1 of the 22 sampled residents and 1 unsampled resident reviewed for safe and homelike environment. The deficient practice was evidenced by the following: On 5/17/26 10:30 AM, the surveyor observed in room [redacted] the surveyor noted the grab bar in the bathroom of room was loose at both ends and pulling away from the wall. The surveyor observed an unopened NJ Ex Order 26.4(b)(1) on the bedside table next to the window bed. On 5/17/26 at 10:58, the surveyor interviewed the U.S. FOIA (b)(6) assigned to the [redacted] floor nursing care unit in room [redacted] The [redacted] was asked about the vial of medication on the bedside table of the window bed. The [redacted] acknowledged medication is not supposed to be left unattended in the room. The [redacted] Acknowledged the medication was an unopened NJ Ex Order 26.4(b)(1) [redacted]. She removed medication from the room and stated she would report the medication found to supervisor. On 5/18/26 at10:00 AM, the survey interviewed the U.S. FOIA (b)(6) for the second floor nursing care unit. The surveyor asked about the unopened NJ Ex Order 26.4(b)(1) at the bedside table. The [redacted] acknowledged this was a medication for Resident #28 and acknowledged medications should not be left unattended at any time. On 5/18/2026 at 11:05 AM The surveyor interviewed the U.S. FOIA (b)(6) The [redacted] was made aware of the medication found in room [redacted] on 5/17/26 and acknowledged that medications including NJ Ex Order 26.4(b)(1) should never be left unattended in resident rooms. On 5/19/2026 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b)(6) The surveyor asked about loose grab bar next to resident's toilet in room [redacted] The [redacted] acknowledged the rail is in place to assist residents with transfers to and from toilet and presented a safety hazard to the resident's if it was not fastened to the wall securely. The [redacted] stated he would repair the loose grab bar immediately. On 5/19/2026 at 1:10PM, the surveyor and the survey team met with the U.S. FOIA (b)(6) [redacted]) and the [redacted] Both acknowledged that the loose bathroom grab bar in	F0689	Continued from page 19 the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing and Unit Managers completed room-to-room bedside checks for all 110 residents and identified no medications or nebulization treatments left at the bedside. The Director of Nursing provided education to all licensed nursing staff regarding the medication administration policy and the importance of ensuring that no medications or treatments are left unattended at the bedside. The Administrator implemented a weekly rounding schedule with the Maintenance Director to inspect grab bars in resident bathrooms and identify any areas requiring repair or improvement. The Administrator also provided education to the U.S. FOIA (b)(6) on the importance of preventive maintenance and supported the development of a structured schedule for routine inspection and servicing of identified areas requiring repair. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Unit Managers will conduct in-room audits of ten residents to ensure no medications are left at the bedside, twice weekly for two weeks, followed by audits of ten residents once weekly for an additional two weeks. The Maintenance Director will conduct daily rounds and perform audits of grab bar stability in ten bathrooms twice weekly for two weeks, followed by audits of ten bathrooms once weekly for an additional two weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI)	07/08/2026

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 05/21/2026

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F0689 SS = D	Continued from page 20 room [NJ Ex O] and the observation of an unattended medication in the same room both presented a potential hazard to resident safety. On 05/20/2026 11:50 AM, the surveyor Interviewed Resident #10. The resident acknowledged he used grab bar during transfers to and from the toilet. A review of electronic health record (EHR) for resident #10 reflected the resident was admitted to the facility with diagnoses that included [NJ Ex Order] [redacted], a history of [NJ Ex Order] and [NJ Ex Order 26.4(b)] [redacted] A review of Resident #10's annual Minimum Data Set (MDS), an assessment tool, reflected that the resident is NJ Ex Order 26.4(b)(1) and the resident requires assistance with [NJ Ex Order 26.4(b] [redacted] On 5/20/26 at 12:05 PM, the surveyor interviewed Resident #28. The resident acknowledged [NJ E] [redacted] received NJ Ex Order 26.4(b)(1) previously and stated [NJ E] [redacted] refused to take any more but could not recall when they stopped giving them to [NJ Ex O] [redacted] A review of Resident #28's EHR reflected the resident was admitted to the facility with diagnoses that included but were not limited to [NJ Ex Order 2] [redacted] and a need for assistance with [NJ Ex Order 26.4(b] [redacted] A review of Resident #28's annual Minimum Data Set (MDS), an assessment tool, reflected that the resident has NJ Ex Order 26.4(b)(1) A review of Resident #28's physician orders reflected the resident was ordered [NJ Ex Order 26.4(b)(1)] [redacted] every 12 hours. The order was dated to start on [NJ Ex Order 26] [redacted] and discontinued on [NJ Ex Order 2] [redacted]	F0689	Continued from page 20 Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence,	F0690	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #13's NJ Ex Order 26.4(b)(1) was properly secured and repositioned away from the door and the roommate's view. A new appropriately sized [NJ Ex Order 26.4(b)(1)] was obtained and applied to fully cover the [NJ Ex Order 26.4(b)(1)] ensuring that [NJ Ex Order 26.4] was visible. How the facility will identify other residents having the potential to be affected by the same deficient	07/08/2026

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE , WAYNE, New Jersey, 07470

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F0690 SS = D	Continued from page 21 based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident with NJ Ex Order 26.4(b)(1) [redacted] had NJ Ex Order 26.4(b)(1) for dignity. This deficient practice was identified in 1 (one) of 3 residents (Resident #13) who were reviewed for NJ Ex Order 26.4(b)(1) use. This deficient practice was evidenced by the following: On 5/17/26 at 10:01 AM, the surveyor observed Resident #13 lying in bed awake, able to answer the surveyor's inquiry. The surveyor observed that the resident's NJ Ex Order 26.4(b)(1) is on the NJ Ex Order 26.4(b) of the bed, not in the NJ Ex Order 26.4(b)(1) facing the door and the roommate. On the same day, the surveyor interviewed the U.S. FOIA (b)(6) [redacted]), who stated that the resident should have a NJ Ex Order 26.4(b)(1) On 5/19/26 at 8:57 AM, the surveyor observed that Resident #13's NJ Ex Order 26.4(b)(1) has NJ Ex Order 26.4([redacted], but the NJ Ex Order 26.4(b)(1) covers half of the NJ Ex Order 26.4([redacted]; the remaining NJ Ex Order 26.4(b)(1) is visible and exposing NJ Ex Order 26.4(b [redacted].	F0690	Continued from page 21 practice. All residents with foley catheter have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing and Unit Managers conducted an audit of all residents with Foley catheters and identified no additional concerns related to drainage bag positioning or privacy bag placement. Unit Managers were designated as primarily responsible for ensuring that drainage bags are appropriately positioned when residents are in bed and that privacy bags are properly fitted to provide full coverage. The Director of Nursing provided education to all licensed nursing staff and certified nursing assistants regarding the facility's Quality of Life and Dignity policy, including the importance of maintaining privacy by ensuring urinary catheter drainage bags remain appropriately covered. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Unit Managers will conduct daily audits of all residents with Foley catheter drainage bags to ensure proper positioning and coverage for two weeks, followed by audits three times per week for an additional two weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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F0690 SS = D	Continued from page 22 On 5/19/26 at 9:00 AM, the surveyor, together with the U.S. FOIA (b)(6), went to the resident's room. The U.S. FOIA (b)(6) stated that the NJ Ex Order 26.4(b)(1) should cover the whole NJ Ex Order 26.4(b)(1), and the NJ Ex Order should not be exposed since the resident had a roommate. On 5/19/25 at 9:31 AM, the surveyor reviewed the hybrid (paper and electronic) medical record of Resident #13, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #13 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A review of the recent quarterly Minimum Data Set (Q/MDS) (an assessment tool used to facilitate the management of care) of NJ Ex Order 26.4(b)(1) indicated that the facility assessed the residents' NJ Ex Order 26.4(b)(1) status using a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1). Further review of Q/MDS, as reflected in Section NJ Ex Order 26.4(b)(1), revealed that Resident #13 had an NJ Ex Order 26.4(b)(1) A review of the Order Summary Report (OSR) revealed an active order for NJ Ex Order 26.4(b)(1) care every shift as of NJ Ex Order 26.4(b)(1) A review of the Care Plan (CP) report initiated on NJ Ex Order 26.4(b)(1) that focuses on Resident #13 has a NJ Ex Order 26.4(b)(1) and NJ Ex Order Interventions included, but were not limited to, a NJ Ex Order 26.4(b)(1) at all times. On 5/19/26 at 1:40 PM, the team of surveyors met with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) regarding the concern above, but did not provide further information.	F0690		07/08/2026

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F0690 SS = D	Continued from page 23 A review of the facility policy title "Quality of Life - Dignity" stated under "Policy Interpretation and Implementation 11. a. Helping the resident to keep urinary catheter bags covered." NJAC 8:39-33.2(c)5	F0690		07/08/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documents, it was determined that the facility failed to ensure that residents received the necessary NJ Ex Order 26.4(b)(1) care and services, according to the standard of clinical practice, specifically documenting PRN (as needed) o NJ Ex Order 26.4(b)(1) and provide enough water in the NJ Ex Order 26.4(b)(1) according to the facility's policy and procedure for 1 (one) of 1 resident (Resident #15) reviewed for NJ Ex Order 26.4(b)(1) care. This deficient practice was evidenced by the following: 1. On 5/17/2026 at 10:35 AM, the surveyor observed a NJ Ex Order 26.4(b)(1) on the bedside table of the window bed in room NJ Ex O .The tubing of the NJ Ex Order 26.4(b) lying on floor behind the bedside table, the surveyor was unable to visualize the date on the NJ Ex Order 2 On 5/17/2026 at 10:54 AM, the surveyor asked the U.S. FOIA (b)(6) to observe NJ Ex Order 26.4(b)(1), the NJ Ex Order 26.4(b)(1) in was trailing on the floor behind the bedside table. The U.S. FOIA picked up NJ Ex Order 2 and there was no NJ Ex Order 26.4(b)(1) attached to the end of NJ Ex Order 26.4(b) , The NJ Ex Order 2 was marked with a tape flap, which was dated NJ Ex Order 26.4 On 5/17/2026 10:58 AM, the Surveyor interviewed	F0695	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #15's NJ Ex Order 26.4(b)(1) was immediately replaced. The NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1) that was found on the floor in Room # NJ Ex O was immediately discarded and replaced with new NJ Ex Order 2 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving nebulizer treatments or requiring oxygen humidification have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing and Unit Managers conducted an audit of all residents receiving nebulizer treatments and requiring oxygen humidification and identified no additional residents affected by this practice. Unit Managers were designated as primarily responsible for ensuring that nebulizer tubing is properly replaced, dated, bagged, and maintained in accordance with facility policy and infection prevention standards. Unit Managers were also designated responsible for ensuring that all residents requiring oxygen humidification have appropriately filled humidifier bottles with the correct water source, as required by facility policy and physician orders. The Director of Nursing provided education to all licensed nursing staff regarding the facility's	07/08/2026

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F0695 SS = D	Continued from page 24 the U.S. FOIA (b)(6) assigned to the care for Resident #28. The U.S. FOIA acknowledged the NJ Ex Order was dated NJ Ex Order 26.4 The U.S. FOI could not state what the facility policy was for changing NJ Ex Order 26.4(b) On 5/18/2026 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b)(6)). The U.S. FOIA acknowledged NJ Ex Order and NJ Ex Order 26.4(b)(1 are changed on a once a week schedule and this NJ Ex Order was three weeks overdo for change. A review of the facility provided policy titled Administering Medications through a Small Volume Handheld Nebulizer reflects … change equipment and tubing every seven days according to protocol. 2. On 5/17/26 at 9:52 AM, the surveyor observed Resident #15 asleep in bed with NJ Ex Order 26.4(b)(1) attached to the NJ Ex Order 26.4(b)(1) . It was observed that the NJ Ex Order 26.4(b)(1) attached to the NJ Ex had less than NJ Ex Order 26.4(b)(1). On 5/18/26 at 8:58 AM, the surveyor observed that Resident #15 was asleep with NJ Ex Order 26.4(b)(1) and the water from the NJ Ex Order 26.4(b)(1) attached to the NJ Ex Order 26.4(b)(1) was almost empty. On the same day at 9:04 AM, the surveyor interviewed the U.S. FOIA (b)(6)), who was inside the resident's room at that time. U.S. FOIA stated that Resident #15 was using NJ Ex daily. The U.S. FOIA added that the nurses are the ones changing the NJ Ex Order 26.4(b)(1). On 5/18/26 at 9:08 AM, the surveyor, together with the U.S. FOIA (b)(6)), showed the U.S. FOIA (b)(6) that the water humidifier attached to the resident's NJ Ex Order 26.4(b)(1) had less than NJ Ex Order 26.4(b)(1) . On the same day at 12:20 PM, the surveyor observed that the NJ Ex Order 26.4(b)(1) was almost empty. The U.S. FOIA (b)(stated that the nurse will change the NJ Ex Order 26.4(b)(1) right away. On 5/18/26 at 10:25 AM, the surveyor reviewed the electronic Medical Record (eMR)/ hybrid medical record (paper and electronic) of Resident #15, which revealed the following: A review of the Admission Record (AR, an admission summary) reflected that Resident #15 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1)	F0695	Continued from page 24 Oxygen Administration Policy. The education included proper oxygen humidification requirements, and documentation of treatment administration in the resident's progress notes. The Director of Nursing and MDS Coordinator were designated responsible for ensuring that resident care plans are reviewed and remain consistent with current physician orders and prescribed treatments. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Unit Managers will conduct an audit of all residents with nebulizer treatment and residents requiring humidification two times weekly for two weeks, followed by audits once a week for an additional two weeks. The Director of Nursing will conduct an audit of 10 residents care plan and progress notes documentation once a week for four weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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 05/21/2026

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
F0695 SS = D	Continued from page 25 NJ Ex Order 26.4(b)(1) A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care) with an assessment reference date (ARD) (the last day of the observation period) of NJ Ex Order 26 indicated that the facility assessed the residents' NJ Ex Order 26.4(b) status using a Brief Interview for Mental Status (BIMS) score of N out of 15, which indicated that the resident had NJ Ex Order 26.4(b)(1) A review of the Order Summary Record (OSR), the physician ordered NJ Ex Order 26.4(b)(1) PRN (as needed) with the start date of NJ Ex Order 2. A review of the electronic Medication Administration Record (eMAR) schedule for NJ Ex Order 26.4(b) revealed that there is no documentation of NJ Ex Order 26.4(b)(1), that Resident #15 received NJ Ex Order 2. A review of the Care Plan (CP) report initiated on NJ Ex Order 26.4(b) focused on Resident #15, who is on [Name Redacted] NJ Ex Order 26. care. Interventions included, but were not limited to, providing NJ Ex as needed. On 5/18/26 at 9:10 AM, the surveyor interviewed the U.S. FOIA who is assigned to the resident. The U.S. FOIA stated that she should document that the resident received the PRN O2 used and assess the resident to determine if the treatment was effective. There is no added information provided on where the documentation was located. On 5/19/26 at 1:13 PM, the team of surveyors met with the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) to discuss the above concern; no additional information was provided. A review of the facility policy titled “Oxygen Administration” revealed under “Steps in the Procedure 12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened. Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. Documentation: After completing the oxygen setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed.” NJ 8:39-25.2(c)3	F0695		07/08/2026

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F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) consistently ensure an "as needed" (PRN) [NJ Ex O] medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing for (one) 1 of four (4) residents (Resident #18), administered by one (1) of four (4) nurses, observed during medication administration; and b) provide pharmaceutical services in accordance with professional standards to ensure appropriate transcription and administration of a medication for 1 of 22 residents (Resident #125) reviewed. This deficient practice was evidenced by the	F0755	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The [U.S. FOIA (b)(6)] assigned to Resident #18 was immediately re-educated on as-needed (PRN) medication administration protocols, including adherence to the Five Rights of Medication Administration. Resident #125 is no longer a resident of the facility. A retrospective review of Resident #125's Medication Administration Records (MARs) was completed and revealed no adverse outcomes or negative impact related to the identified practice. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing and Unit Managers conducted an audit of all residents with PRN pain medication orders, specifically focusing on acetaminophen [NJ Ex Order 26] orders and corresponding medication administration documentation. The audit included verification of medication transcription accuracy and prescribed dosing. No additional residents were identified as being affected by this practice. Unit Managers were designated responsible for reviewing Pharmacy Consultant reports to ensure that any medication transcription discrepancies are promptly identified, addressed, and corrected. The Administrator and/or Director of Nursing will meet with the Pharmacy Consultant to review current chart review processes and communication procedures for identifying and reporting medication transcription errors. The Director of Nursing provided education to all licensed nursing staff regarding physician order transcription requirements and the facility's	07/08/2026

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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

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F0755 SS = D	Continued from page 27 following: 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 responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 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 licensed or otherwise legally authorized physician or dentist." 1. On 5/18/26 at 9:18 AM, the surveyor observed U.S. FOIA (b)(6) assigned to the middle cart of the first-floor, prepared medications for Resident #18. The physician's orders (PO) included NJ Ex Order 26.4(b)(1) , give 2 tablets by mouth every 4 hours "PRN" for NJ Ex Order 26.4(b)(1) not to exceed 3 grams from all sources within 24 hours. The order started on NJ Ex Order 26.4(b) At 9:36 AM, the surveyor observed the U.S. FOIA (b)(6) complete a third check of the medications against the electronic Medication Administration Record (eMAR). The U.S. FOIA (b)(6) confirmed she had 8 pills in the medication cup, was ready to administer, and did not include the NJ Ex Order 26.4(b)(1) The U.S. FOIA (b)(6) stated that she would take Resident #18's NJ Ex Order 26.4(b)(1) prior to the administration of their NJ Ex Order 26.4(b)(1) medication NJ Ex Order 26.4(b)(1) and their NJ Ex Order 26.4(b)(1) At 9:40 AM, the surveyor observed the U.S. FOIA (b)(6) administer NJ Ex Order 26.4(b)(1) to Resident # 18 who stated they experienced [redacted] and requested for their NJ Ex Order 26.4(b)(1) The surveyor observed the U.S. FOIA (b)(6) acknowledged Resident #18's request and took Resident 18's NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1) then exited the resident's room. At 9:49 AM, the surveyor observed the U.S. FOIA (b)(6) prepare	F0755	Continued from page 27 medication administration policy, with emphasis on accurate order entry, verification of medication orders, and compliance with safe medication administration practices. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Unit Managers will conduct audits of all residents with PRN medication orders to ensure accurate physician order transcription and medication administration record documentation. Audits will be conducted twice weekly for two weeks, followed by once-weekly audits for an additional two weeks. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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F0755 SS = D	Continued from page 28 Resident #18's NJ Ex Order 26.4(b) and the NJ Ex Order 26.4 At 9:57 AM, the U.S. FOL confirmed with the surveyor that she was ready to administer Resident #18's NJ Ex Order 26.4(b)(1). The prepared medications did not include the NJ Ex Order 2 At 9:58 AM, the surveyor observed the U.S. FOL enter Resident #18's room. At 9:59 AM, the surveyor observed the U.S. FOL administered Resident #18's NJ Ex Order 26.4(and their NJ Ex O [redacted] At that time, the Resident refused their NJ Ex Orde and requested for their NJ Ex Order again. The surveyor observed the U.S. FOL exit the resident's room. At 10:03 AM, the surveyor observed the U.S. FOL signed the eMAR for the administered medications that did not include the NJ Ex Order 2 At 10:05, the surveyor observed the NJ Ex Or opened the eMAR for Resident #18's roommate. At 10:06 AM, the surveyor observed the U.S. FOL enter the room, addressed Resident 18's roommate and asked if they were ready for the administration of their medication. At 10:08 AM, the surveyor and U.S. FOL reviewed Resident #18's eMAR together. At that time, the surveyor asked the U.S. FOL why she did not administer Resident #18's PRN NJ Ex Order when the resident had requested for their NJ Ex Ord medication. At that time, the U.S. FOL confirmed and acknowledged that she had forgotten to administer the medication. The U.S. FOL stated she would inform the prescriber and supervisors of the concern. The surveyor reviewed the medical record for Resident #18. According to the Admission Record, (face sheet) an admission summary, Resident #18 was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 2 [redacted] and NJ Ex Order 26.4(b)(1) A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4 , reflected a Brief Interview for Mental Status (BIMS) score of NJ E out of 15 which indicated Resident #18 was NJ Ex Order 26.4(b)(1). Further	F0755		07/08/2026

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F0755 SS = D	Continued from page 29 review of the MDS reflected that a [NJ Ex Or] assessment interview should be conducted. A review of the Care Plan (CP) included a focus on the potential and/or alteration on [NJ Ex Order 26.4(b)(1)]. The interventions included, to notify physician of interventions were unsuccessful or if current complaint is a significant change from resident's "past" experience of [NJ Ex Ord]. The focus and interventions were initiated on [NJ Ex Order 26.4]. On 5/19/26 at 1:13 PM, during a meeting with the survey team, the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)]), the surveyor discussed the concern that occurred during the medication pass observation wherein the [U.S. FOI] had omitted the PRN [NJ Ex Order] medication that Resident #18 had requested. On 5/20/26 at 11:03 AM, during a meeting with the survey team, and the [U.S. FOIA (b)] the [U.S. FOIA] confirmed and acknowledged that the PRN pain medication should have been offered when the resident had requested the medication. No further information was provided. A review of the facility provided policy, titled Administering Medications, dated/revised 4/2019 included that medications are administered in accordance with prescriber orders, including any required time frame. 2. On 5/20/26 at 12:30 PM, the surveyor reviewed the electronic medical record (EMR) for Resident #125. The resident no longer resided at the facility. The Admission Record revealed Resident #125 had diagnoses that included but were not limited to [NJ Ex Order 26.4(b)(1)] A physician's order dated [NJ Ex Order 26] indicated to give [NJ Ex Order 26.4(b)(1)]) tablet, 2 tablets by mouth three times a day for [NJ Ex Or] management. In addition, the order entry indicated "3 tabs = [NJ Ex Order 26.4(b)] A review of Medication Administration Record (MAR) and progress notes revealed no documentation regarding clarification of the order dosage. On 5/20/26 at 1:49 PM, the surveyor informed the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)] of the concern	F0755		07/08/2026

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F0755 SS = D	Continued from page 30 regarding Resident #125's Tylenol order 2 tablets versus 3 tablets was not identified and clarified. On 5/21/26 at 10 AM, the [U.S. FOIA (b)] and the [U.S. FOIA] [U.S. FOIA] met with the survey team. The stated in-service education was provided to the staff regarding medication orders including transcription and medication administration. There was no additional information provided by the facility's management. A review of the undated, facility provided policy titled, "Administering Medications", under Policy revealed: Medications are administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation of the policy revealed: 10. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. NJAC 8:39-29.2(d), 2	F0755		07/08/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined the facility failed to: a) administer medications with parameters in accordance with a physician's order and standards of practice for 1 of 2 residents (Resident #96) reviewed for [NJ Ex Order 26] services. The deficient practice is evidenced by the following: 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 responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as	F0760	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #96's Medication Administration Records (MARs) for [NJ Ex Order 26.4(b)] and [NJ Ex Order 26.4(b)(1)] were immediately reviewed from [NJ Ex Order 26.4(b)] forward. The review identified no adverse outcomes or negative effects related to the resident. Resident #96's attending physician was notified of the inconsistent vital sign documentation and the corrective actions implemented to address the identified concern. How the facility will identify other residents having the potential to be affectedAll residents have the potential to be affected by this practice. by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	07/08/2026

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F0760 SS = D	Continued from page 31 prescribed by a licensed or otherwise legally authorized physician or dentist." 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 licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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 licensed or otherwise legally authorized physician or dentist." 2. On 5/18/26 at 9:48 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #96. The Admission Record (a summary of important information about the resident) documented that the resident had diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted] NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted] A comprehensive Minimum Data Set (MDS) assessment, an assessment tool to facilitate the management of care, dated [redacted], indicated the facility assessed the resident's [redacted] using a Brief Interview Mental Status (BIMS) test. Resident #96 scored [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) . A physician's order dated [redacted] indicated to give NJ Ex Order 26.4(b)(1) [redacted] one tablet by mouth three times a day; and to hold for [redacted] greater than [redacted]. The medication was scheduled to be given to Resident #96 at 9:30 AM, 1:30 PM, and 5:30 PM. A physician's order dated [redacted] indicated to give NJ Ex Order 26.4(b)(1) [redacted]) one tablet by mouth two times a day for [redacted]; and to hold for NJ Ex Order 26.4(b)(1) [redacted] less than [redacted] and [redacted] less than [redacted]. The medication was scheduled to be given to Resident #96 at 12 PM and 6 PM. A review of the [redacted] Medication Administration Record (MAR) revealed: -There was no documentation of the [redacted] results at the time of the [redacted] medication's	F0760	Continued from page 31 The Director of Nursing conducted a comprehensive review of Resident #96's current medication regimen, including all medications with physician-ordered parameters. Verification was completed to ensure that nursing staff caring for the residents understood and followed the prescribed hold parameters. Unit Managers were designated responsible for reviewing Pharmacy Consultant reports to ensure that any medication parameters discrepancies are promptly identified, addressed, and corrected. The Administrator and/or Director of Nursing will meet with the Pharmacy Consultant to review current chart review processes and communication procedures for identifying and reporting medication transcription errors. The Director of Nursing provided education to all licensed nursing staff regarding physician orders for medications with administration parameters and the facility's Medication Administration Policy. Education emphasized accurate transcription of physician orders, proper documentation of required assessments, verification of medication parameters prior to administration, and compliance with safe medication administration practices. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Unit Managers will conduct audits of residents with medication orders that require assessment of specific parameters prior to administration. Audits will be conducted twice weekly for two weeks, followed by once-weekly audits for an additional two weeks to ensure compliance with physician orders and facility medication administration policies. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE , WAYNE, New Jersey, 07470

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F0760 SS = D	Continued from page 32 administration to the resident. -There was no documentation of the NJ Ex Order 26.4(b)(1) and NJ Ex results at the time of the NJ Ex Order 26.4(b)(1) medication's administration to the resident. A review of the NJ Ex Order 26.4 and Vitals section of the EMR revealed no consistent documentation of Resident #96's NJ Ex and NJ Ex for each NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) administration to reflect that the medications were administered as per the physician's orders. A review of progress notes revealed no additional documentation of Resident #96's NJ Ex and NJ Ex result for each medication's administration. On 5/7/26 at 1:39 PM, the surveyor interviewed a U.S. FOIA (b)(6)) about medications with parameters. The U.S. FOIA stated at the time of the medication's administration the resident's NJ Ex and NJ Ex were checked; the results were documented in the MAR; and the medication was administered according to the physician's order. The U.S. FOI with the surveyor reviewed the NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1) orders for Resident #96. The U.S. FOI confirmed the medication orders included parameters. Upon further review the U.S. FOI explained the orders did not include the supplementary documentation section for the nurses to document the NJ Ex and/or NJ Ex results. The U.S. FOI stated the nurses could document under the Vital Signs (VS; measurement of NJ Ex Order 26.4 temperature and NJ Ex Order 26.4(b)(1) rate) section of the EMR if there was no supplementary documentation to note a resident's NJ Ex Order 26.4(b)(1) at the time of a medication's administration. On 5/18/26 at 11:05 AM, the surveyor interviewed the U.S. FOIA (b)(6)) who stated the nurses documented the NJ Ex and NJ Ex results in the supplementary documentation section of the medication order in the MAR. The U.S. FOIA (b)(6) with the surveyor reviewed Resident #96's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) order MAR entries. The U.S. FOIA (b)(6) confirmed there was supplementary documentation section in the MAR and proceeded to check the VS section of the EMR. The U.S. FOIA (b)(6) acknowledged there was no consistent documentation of the NJ Ex and NJ Ex results at the time of each medication administration. The U.S. FOIA (b)(6) stated it would be expected for the nurse to document the results in the EMR and to inform the U.S. FOIA (b)(6) if an order needed to be clarified.	F0760		07/08/2026

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 05/21/2026

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
F0760 SS = D	Continued from page 33 On 5/19/26 at 1:12 PM, the surveyor informed the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)) of the above concerns. On 5/20/26 at 11:02 AM, the U.S. FOIA (b and the U.S. FOIA met with survey team. The U.S. FOIA stated that supplementary documentation sections for the identified orders were added, and education was provided to the staff. There was no additional information provided by the facility. The surveyor reviewed the undated facility provided policy titled, "Administering Medications" which revealed under Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Under Policy Interpretation and Implementation of the policy revealed: 4. Medications are administered in accordance with prescriber orders, including any time frame. 11. The following information is checked/verified for each resident prior to administering medications: VS, if necessary. The policy did not further address medication with parameters and documentation of VS at medication administration. NJAC 8:39-11.2 (b); 29.2(d)	F0760		07/08/2026
F0761 SS = D	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 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.	F0761	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The unlabeled, opened Silver Sulfadiazine (SSD) cream and the opened sterile gauze were immediately discarded. The NJ Ex Order 26.4(b items belonging to Unsampled Resident #102 were immediately removed and appropriately discarded. The U.S. FOIA (b)(6)) who identified these items during the survey process was immediately re-educated on proper medication labeling requirements, sterile supply handling and storage. How the facility will identify other residents having the potential to be affected by the same deficient practice.	07/08/2026

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 05/21/2026

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F0761 SS = D	Continued from page 34 §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 observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a prescription medication was labeled, sterile treatment supply and IV treatment were stored and discarded in accordance with currently accepted professional principles and facility's policy. This deficient practice was identified for 1 of 3 medication carts inspected and was evidenced by the following: 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 responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." On 5/19/25 at 10:02 AM, the surveyor inspected the NJ Ex Or-floor South treatment cart, in the presence of the U.S. FOIA (b)(6)). During the inspection the surveyor and the U.S. FOI observed the following: -unlabeled, opened, dated 5/18/26, Silver Sulfadiazine cream (SSD (Silvadene; a prescription topical antibacterial cream used for the prevention and treatment of wound sepsis for those with second- and third-degree burn). -opened sterile [brand redacted] gauze sponge (used for protective coverage, absorbent for drainage from wounds, packed into deeper wound, for wound cleansing or to wipe away debris. NJ Ex Order 26.4(b)(1) for Unsampled Resident #102 NJ Ex Order 26.4(b)(1)	F0761	Continued from page 34 All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing and Unit Managers conducted a comprehensive audit of all medication and treatment carts and identified no additional unlabeled or improperly stored items. Unit Managers were designated responsible for routinely inspecting medication and treatment carts to ensure that no unlabeled, open, or unused items are stored within the carts. An audit tool and checklist with required sign-off documentation was developed to support accountability and ensure ongoing compliance. The Administrator and/or Director of Nursing will meet with the Pharmacy Consultant to review current cart inspection processes and strengthen monitoring procedures. The Director of Nursing provided education to all licensed nursing staff regarding the facility's Medication Labeling and Storage Policy. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing will conduct medication and treatment cart audits twice weekly for two (2) weeks, followed by once-weekly audits for an additional two (2) weeks to ensure compliance with the facility's medication labeling and storage policy. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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 05/21/2026

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
F0761 SS = D	Continued from page 35 NJ Ex Order 26.4(b)(1) [redacted]	F0761		07/08/2026

At 10:13 AM, the surveyor and the U.S. FOI reviewed the items found in the treatment cart. At that time, the U.S. FOI confirmed and acknowledged that the SSD should have had a pharmacy label with the resident's name to reflect who the medication belonged to and applied to the correct resident. The U.S. FOI also stated that it should have been stored in a plastic bag to prevent cross contamination of house stocked creams.

At that time, the U.S. FOI stated that the sterile gauze once opened were no longer sterile, was for one time use, should have been discarded and not stocked in the treatment cart for further use.

At that time, the U.S. FOI confirmed that the NJ Ex Order 26.4(b should have been stored with the NJ E cart. The surveyor and the U.S. FOI reviewed the electronic Medical Record (eMR) together which reflected that the NJ Ex Order 26 was discontinued on NJ Ex Order . At that time, the U.S. FOI stated it should have been removed from active inventory. The U.S. FOI informed the surveyor that she would remove all the items, discard the items and inform her supervisors.

On 5/19/26 at 1:13 PM, during a meeting with the survey team, the U.S. FOIA (b)(6) [redacted] and the U.S. FOIA (b)(6) [redacted] the surveyor discussed the concern with the unlabeled prescription antimicrobial SSD cream, commingled with over-the-counter treatment, the opened sterile gauze, the NJ Ex Order 26.4(b in the treatment cart that was for Unsampled Resident #102 and was discontinued on NJ Ex Order 2

On 5/20/26 at 11:03 AM, during a meeting with the survey team, and the U.S. FOIA (b) the U.S. FOIA acknowledged and confirmed that the SSD cream should have been labeled, the gauze and the NJ Ex Order 26.4(b should have been discarded. The U.S. FOIA also stated that education regarding proper storage was provided to staff.

No further information was provided.

A review of the facility provided policy, titled Storage of Medication, dated/revised 11/2020 included that the facility stored all drugs and biologicals in a safe, secure, and orderly manner. Drug containers that had missing, incomplete, improper, or incorrect labels were returned to the pharmacy for proper labeling before storing. Discontinued outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F0761 SS = D	Continued from page 36 NJAC 19.8(c)(g),29.4(a)(h), 29.7(b)	F0761		07/08/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical	F0842	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #125 is no longer at the facility; however, a retrospective chart review was completed, documentation discrepancies were addressed, and all identified missing documentation were addressed and submitted accordingly. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Director of Nursing provided mandatory education to all nursing staff, including Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Certified Nursing Assistants (CNAs), regarding the facility's documentation policy. The education included requirements for proper documentation, including emergency contact information and notification procedures. The Director of Nursing also implemented a new daily documentation review process utilizing a standardized checklist to identify and correct documentation deficiencies within 24 hours of identification. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing will conduct daily audits of resident medical records five days a week for four weeks to ensure complete and accurate documentation of nursing assessments, progress	07/08/2026

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F0842 SS = D	Continued from page 37 examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Complaint #2713977 Based on observation, interview, and record review, it was determined that the facility failed to maintain accurately documented, complete and readily accessible medical records. This deficient practice was identified for 1 of 22 residents (Resident #125) reviewed. On 5/18/26 at 9:09AM, the surveyor reviewed the electronic medical record (EMR) of Resident #125. The resident no longer resided at the facility. The Admission Record (a summary of important	F0842	Continued from page 37 notes, and emergency contact notifications. The unit managers will conduct daily audits of Certified Nursing Assistant (CNA) task documentation to verify completion, no blank or unsigned entries and that all documentation is properly completed. The Administrator and Director of Nursing will conduct a weekly review of all incident investigations to ensure appropriate and complete documentation in resident medical records, including verification that emergency contact notifications were completed. Audit results will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings to evaluate compliance trends and determine if additional corrective actions are necessary to achieve and maintain 100% compliance.	07/08/2026

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F0842 SS = D	Continued from page 38 information about the resident) documented that the resident had diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated NJ Ex Order 26.4(indicated the facility assessed the resident's NJ Ex Order 26.4(using a Brief Interview Mental Status (BIMS) test. Resident #125 scored NJ E out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1). Resident #125 was coded as NJ Ex Order 26.4(b)(1 on assistance for NJ Ex Order 26.4(b)(1); required NJ Ex Order 26.4(b)(1) assistance with NJ Ex Order 26.4(b)(1) and was frequently NJ Ex Order 26.4(b)(1). A review of a physician progress note, by the U.S. FOIA (b)(6) dated NJ Ex Order at 4:06 PM documented Resident #125 had NJ Ex Order 26.4(b)(1) and was unaware if they NJ Ex Order 26 the area was NJ Ex Order but now it was NJ Ex Order 2 In addition, the note documented the resident was last seen by the U.S. FOIA two days ago, NJ Ex Order 26.4 now looks NJ Ex Order 26.4(b)(1), instructed for NJ Ex avoid NJ Ex Order 26.4(b)(1)" to the site. The U.S. FOIA documented they discussed with Resident #125's "[relation to the resident]" at the bedside. A review of progress notes for NJ Ex Order 26.4(b)(1) revealed no nursing documentation regarding the resident sustaining NJ Ex Order 26.4(b)(1) or notification to the U.S. FOIA or emergency contact (EC). On 5/18/26 at 1:00 PM, the surveyor requested from the U.S. FOIA (b)(6) any investigations for Resident #125 for NJ Ex Order 26.4(b)(1) The U.S. FOIA stated they were not the in r 26.4(b)(1) and would review facility records to provide the requested information. On 5/19/26 at 9:24 AM, the surveyor reviewed the facility provided investigation dated NJ Ex Order 2 which indicated during rounds the (former) was notified the resident was found with NJ Ex Order 26.4(b)(1) . The documents included a summary of the investigation including written staff statements; an assessment of the resident's status; a review of potential causes and risk factors; and a conclusion. The investigation under notification revealed notified	F0842		07/08/2026

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F0842 SS = D	Continued from page 39 resident representative written as "[relation to the resident]". There was no documented name of the EC, date or time of notification. There was no documentation found in the resident's medical record to indicate notification to the resident's EC regarding their NJ Ex Order 26.4(b)(1) in NJ Ex Order 26.4(b)(1) On 5/19/26 at 10:48 AM, the surveyor interviewed a Registered Nurse (RN) who cared for Resident #125. The RN stated they recalled the resident had a NJ Ex Order 26.4(b)(1) like a NJ Ex Order 26.4(b)(1) but could not recall more details of what had occurred during that time. The RN acknowledged that if there was a change in a resident's status, their EC/resident representative should be notified, and it should be documented by the nurse. On 5/19/26 at 1:12 PM, the surveyor informed the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)) of the concern there was no documentation of notification to Resident #125's EC regarding the NJ Ex Order 26.4(b)(1) and there was no nursing documentation related to the NJ Ex Order 26.4(b)(1) The surveyor additionally requested for review a copy of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) Resident #125's Tasks documentation report, a record where the CNA's document and sign for care provided to the residents. On 5/20/26 at 11:02 AM, the U.S. FOIA (b and the U.S. FOIA U.S. FOIA stated on the investigation provided documented notification to Resident #125's EC. The U.S. FOIA with the surveyor reviewed the investigation document which indicated the "[relation to the resident]" was notified. The U.S. FOIA confirmed there was no name of the person notified, no date, and no time of the notification. The surveyor asked the U.S. FOIA if the investigation was considered part of Resident #125's medical record. The U.S. FOIA replied that it was not part of the resident's medical record. The surveyor informed the U.S. FOIA that there was no documentation in the EMR by the nurses about the NJ Ex Order 26.4(b)(being identified or notification to an emergency contact. There was no verbal response at this time. On 5/20/26 at 12:20 PM, the surveyor interviewed over the phone an U.S. FOIA (b)(6) who worked at the facility in NJ Ex Order 26.4(b)(1). The U.S. FOIA (b)(6) stated that if an NJ Ex Order 26.4(b)(1), such as a NJ Ex Order 26.4(b)(1) identified, part of the	F0842		07/08/2026

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F0842 SS = D	Continued from page 40 reporting and investigating process would be to notify the resident's EC/resident representative. The U.S. FOIA (b)(6) acknowledged that notification to the EC should be documented in a progress note in the EMR. The U.S. FOIA (b)(6) stated that even if a resident was NJ Ex Order 26.4(b)(1), the EC would be made aware of a resident's status change or condition. On 5/21/26 at 9:13 AM, the surveyor reviewed the facility provided NJ Ex Order 26.4(b)(1) (CNA tasks) Documentation Survey Report which revealed unsigned and blank entries. The entries included but were not limited to: -The entry for NJ Ex Order 26.4(b)(1) had 37 of 93 shift entries which were blank and unsigned. -The entry for NJ Ex Order 26.4(b)(1) had 37 of 93 shift entries which were blank and unsigned. -The entry for NJ Ex Order 26.4(b)(1) had 37 of 93 shift entries which were blank and unsigned. The surveyor reviewed the facility provided NJ Ex Order 26.4 (CNA tasks) Documentation Survey Report which revealed unsigned and blank entries. The entries included but were not limited to: -The entry for NJ Ex Order 26.4(b)(1) had 15 of 29 shift entries which were left blank and unsigned. - The entry for NJ Ex Order 26.4(b)(1) had 15 of 29 shift entries which were left blank and unsigned. -The entry for NJ Ex Order 26.4(b)(1) had 15 of 29 shift entries which were left blank and unsigned. On 5/21/26 at 1:24 PM, the surveyor informed the U.S. FOIA (b) of the concerns of unsigned and blank entries for Resident #125's NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 documentation survey report. There was no additional information provided by the facility. The surveyor reviewed the undated facility provided policy titled "Change in a Resident's Condition or Status" which revealed under Policy Interpretation and Implementation: 4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident, including injuries of an unknown source. The policy did not further address documentation of the notification about a resident's change in	F0842		07/08/2026

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F0842 SS = D	Continued from page 41 condition or status. The surveyor reviewed the facility provided policy titled “Activities of Daily Living, Supporting” dated April 2025 which did not address documentation of ADL or incontinence care. NJAC 8:39-27.1 (a) ;35.2	F0842		07/08/2026

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 05/21/2026

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 The facility was not in compliance with the standards in the New Jersey Administrative Code, 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, and enforcement of licensure regulations.	S0000		06/05/2026
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: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 14 of 14 day shifts as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:	S0560	How the corrective action will be accomplished for the residents affected by the deficient practice: No residents were identified nor immediately affected by the failure to provide minimum staffing levels as per state regulation. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents will have the potential to be affected by the same failure to provide minimum staffing levels as per state regulation. Measures or systemic changes made to ensure no recurrence: The staffing coordinator will inform the Director of Nursing or designee of any call outs that result in insufficient certified nursing assistant staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other employees or agency if required. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:	06/15/2026

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 05/21/2026

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
S0560	Continued from page 1 (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report (AAS-11) for the two-week period beginning 5/3/26 through 6/16/26 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.	S0560	Continued from page 1 The Director of Nursing or designee will report any staffing issues on a daily basis to the administrator or designee. Any findings will be followed up immediately. Findings will be documented and reported during the quarterly QAPI meetings for 6 months.	06/15/2026

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 05/21/2026

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S0560	Continued from page 2 The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -05/03/26 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/04/26 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/05/26 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/06/26 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/07/26 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -05/08/26 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -05/09/26 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/10/26 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/11/26 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/12/26 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/13/26 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/14/26 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/15/26 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/16/26 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs.	S0560		06/15/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new	S1405	How the corrective action will be accomplished for the residents affected by the deficient practice: No residents were identified nor immediately affected by the failure to ensure that the 19 out of 130 new employees didn't receive physicals within the required time frames.	06/15/2026

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 05/21/2026

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S1405	Continued from page 3 employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documents it was determined that the facility failed to ensure that new employees received physicals within the required time frames. This was found with 19 of 130 employee files reviewed. The deficient practice was evidenced by the following: 1. On 5/20/26 at 12:30 PM, Surveyor #1 reviewed newly hired employee files, which revealed the following: Employee (E) 64's date of hire (DOH) was [NJ Ex Order 26] and their physical was done on 3/22/25. E 66's DOH was [NJ Ex Order] and their physical was done 9/26/25. E 67's DOH was [NJ Ex Order 2] and their physical was done 9/26/25. E 71's DOH was [NJ Ex Order 26] and their physical was done 8/22/25. E 78's DOH was [NJ Ex Order 26] and their physical was done 11/16/26. E 95's DOH was [NJ Ex Order 2] and their physical was done 1/17/26. E 102's DOH was [NJ Ex Order 26.4] and their physical was done 3/17/26. E 104's DOH was [NJ Ex Order 26] and their physical was done 3/17/26.	S1405	Continued from page 3 How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systemic changes made to ensure no recurrence: The Director of Human Resources will audit weekly the new hire candidates. Director of Human Resources will also ensure all new employees complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. No on boarding or schedule will be given to the candidate until a proper physical is completed within the allowable timeframe. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting quarterly for 2 quarters. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	06/15/2026

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 05/21/2026

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S1405	Continued from page 4 2. On 5/20/26 at 12:30 PM, Surveyor #2 (S#2) reviewed newly hired employee files, which revealed the following: Employee #3, a Licensed Practical Nurse (LPN), hired date of [NJ Ex Order], had a physical examination signed by a physician dated 7/28/25. Employee #7, a staffing coordinator, hired dated [NJ Ex Order 26], had a physical examination signed by a physician and dated 7/28/25. Employee #10, a dietary aide, hired date of [NJ Ex Order 26.4] had a physical examination signed by a physician, and no documented date. Employee #22, a Certified Nurse Assistant (CNA), hired dated [NJ Ex Order], had a physical examination signed by a physician and dated 3/30/26. Employee #28, an LPN, hired date of [NJ Ex Order 26.4] had a physical examination signed by a physician dated 5/13/25. Employee #32, a CNA, hired date of [NJ Ex Order 26.4(b)] had a physical examination signed by a physician dated 11/10/25. Employee #33, a dietary aide, hired date of [NJ Ex Order 26] had a physical examination signed by a physician dated 7/28/25. Employee #36, a CNA, hired date of [NJ Ex Order 26], had a physical examination signed by a physician dated 5/13/25. Employee #40, a CNA, hired date of [NJ Ex Order 26], had a physical examination signed by a physician dated 1/16/26. Employee #46, a CNA, hired date of [NJ Ex Order 26], had a physical examination signed by a physician dated 3/26/26. Employee #50, a cook, hired date of [NJ Ex Order], had a physical examination signed by a physician dated 1/10/25. On 5/20/26 at 1:20 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the Registered Nurse (RN) does not do the physical examination for the new hire; it was the Medical Director who does the physical before the	S1405		06/15/2026

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S1405	Continued from page 5 staff is hired. On 5/21/26 at 10:01 AM, the team of surveyors met with the LNHA, Director of Nursing, and the Regional Human Resources regarding the above concern, but did not provide further information. The facility policy for the new hire was not provided.	S1405		06/15/2026
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to perform a NJ Ex Order 26.4(b)(1) [redacted] as required for new employees hired for NJ Ex Order 26.4(b)(1) infection and disease screening upon hire or within the previous year for 3 of 130 employee files reviewed. This deficient practice was evidenced by the following: On 5/20/26 at 12:30 PM, Surveyor #2 (S #2) reviewed 40 employee health files for staff members who were hired since the previous Department of Health Recertification Inspection.	S1410	How the corrective action will be accomplished for the residents affected by the deficient practice: No residents were identified nor immediately affected by the failure to ensure that the 3 out of 130 new employees didn't receive a two-step Mantoux tuberculin skin test (PPD) as required. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systemic changes made to ensure no recurrence: The Director of Human Resources will audit weekly the new hire candidates. Director of Human Resources will also ensure all new employees complete a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. No on boarding or schedule will be given to the candidate until a proper Mantoux tuberculin is administered and read within the allowable timeframe. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by:	06/15/2026

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 05/21/2026

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S1410	Continued from page 6 Employee #28, a Licensed Practical Nurse (LPN), hired on [NJ Ex Order 26.4(b)(1)] had one of the [NJ Ex Order 26.4(b)(1)] completed on 8/28/24 and 4/5/25. There was no additional documentation in the file to indicate that a [NJ Ex Order 26.4(b)(1)] test or an alternative [NJ Ex Order 26.4(b)(1)] screening was completed upon hire. Employee #102, a Certified Nursing Assistant (CNA), hired on [NJ Ex Order 26.4(b)(1)] had one of the [NJ Ex Order 26.4(b)(1)] administered on 3/3/26, [NJ Ex Order 26.4(b)(1)] after the date of hire. Employee #114, a CNA, hired on [NJ Ex Order 26.4(b)(1)], had one of the [NJ Ex Order 26.4(b)(1)] tests administered on 3/10/26, [NJ Ex Order 26.4(b)(1)] after the ate of hire. On 5/20/26 at 1:10 PM, the surveyor interviewed the LPN/Infection Preventionist (LPN/IP) who confirmed she is responsible for [NJ Ex Order 26.4(b)(1)] and giving [NJ Ex Order 26.4(b)(1)] to new hires; states all employees will receive [NJ Ex Order 26.4(b)(1)] unless previous [NJ Ex Order 26.4(b)(1)] results; asked if the employee has [NJ Ex Order 26.4(b)(1)] states they would still have to receive [NJ Ex Order 26.4(b)(1)] upon hire. Reviewed staff members of concern with the IP who stated she could not speak to the staff files as she was not the responsible person at that time. On 5/20/26 at 1:20 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the nurse would do the [NJ Ex Order 26.4(b)(1)] before hiring. On 5/21/26 at 2:13 PM, the team of surveyors met with the LNHA, Director of Nursing (DON), and the Regional Human Resources met with the survey team. There was no additional information provided by the facility. A review of the facility's policy titled "Tuberculosis Employee Screening for" with the revision date of January 2026 revealed under "Policy Statement: All employees are screened for latent tuberculosis infection (LTBI) and active tuberculosis (TB) disease, using tuberculin skin test (TST) or interferon gamma release assay (IGRA) and symptom screening prior to beginning employment."	S1410	Continued from page 6 The results of the weekly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting quarterly for 2 quarters. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	06/15/2026

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S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of NJ Department of Health the Supplementary Nurse Staffing Report (AAS-12) for the weeks of 5/3/26 through 5/16/26 obtained for the 5/21/26 Standard survey it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: The week of 05/03/26 required 327 staffing hours	S1680	How the corrective action will be accomplished for the residents affected by the deficient practice: Staffing coordinator was educated on the mandatory nurse staffing requirement that the facility shall provide nursing services by registered professional nurses based on the required RN staffing hours for 1 of the 14 days. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. Measures or systemic changes made to ensure no recurrence: The DON/designee will audit weekly the weekly staffing schedules to assure that the required registered professional nurses, licensed practical nurses and nurse aides hours are scheduled appropriately to comply with minimum hours required. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting quarterly for 2 quarters. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	06/15/2026

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 05/21/2026

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S1680	Continued from page 8 and had 296 actual staffing hours, for a difference of -31 hours.	S1680		06/15/2026

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 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/13/2026 in relation to the 05/21/2026 State of New Jersey Re-Licensure 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	F0000		

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 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 07/10/2026

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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: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE , WAYNE, New Jersey, 07470

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/18/2026 and 05/19/2026, Excel Care at Wayne was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(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 Occupancies. Excel Care at Wayne is a 2 story building with Type 2 (111) construction and a partial basement where the sprinkler riser and transfer switch are located. The facility is divided into 8 smoke zones on the first and second floor and 2 smoke zones in the basement. The construction date was 1969. There were 2 passenger elevators serving all 3 levels. There was an exterior 150 kilowatt diesel powered generator that does approximately 50 percent of the building. The facility has 1 wet sprinkler system and a fire alarm system with smoke detectors in the corridors and resident rooms. The facility had 120 licensed beds of which 110 were occupied.	K0000		05/22/2026
K0345 SS = F Bldg. 01	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 05/19/2026 in the presence of the U.S. FOIA (b)(6)) and	K0345	How the corrective action will be accomplished for the residents affected by the deficient practice: No residents were identified nor affected by not having sensitivity testing conducted on all smoke detectors in accordance with NFPA 101:2012 Edition, Section 9.6, 9.6.1 to 9.6.1.5 and NFPA 72: 2010 Edition, Section 14.4.5, 14.4.5.3.1 to 14.4.5.3.7. 57 of 109 smoke detectors were not sensitivity tested. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this practice. Measures or systemic changes made to ensure no	07/08/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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
K0345 SS = F Bldg. 01	Continued from page 1 U.S. FOIA (b)(6)), it was determined the facility failed to ensure sensitivity testing was conducted on all smoke detectors in accordance with NFPA 101:2012 Edition, Section 9.6, 9.6.1 to 9.6.1.5 and NFPA 72: 2010 Edition, Section 14.4.5, 14.4.5.3.1 to 14.4.5.3.7. This deficient practice had the potential to affect all 110 residents and was evidenced by the following: Record review at 1:20 PM of the fire alarm system inspection, testing and maintenance reports revealed, the provided fire alarm inspection report dated 03/12/2026 that contained the last smoke detector sensitivity testing showed that 57 of 109 smoke detectors were not sensitivity tested. 52 smoke detectors were listed as Sensitivity Tested and 57 were listed as Tested/Cleaned. No further documentation of a prior sensitivity test was provided. In an interview at the time the U.S. FO and U.S. FOIA confirmed the record review and the U.S. FO stated that the smoke detectors listed as Tested/Cleaned were functionally tested, not Sensitivity tested. The facility's U.S. FOIA (b)(6) U.S. FO and U.S. FOIA were informed of the deficient practice at the Life Safety Code exit conference on 05/19/2026 at 2:28 PM. N.J.A.C. 8:39-31.2(e) NFPA 72	K0345	Continued from page 1 recurrence: The Director of Maintenance revised the Fire Alarm System Inspection, Testing and Maintenance Program to clearly distinguish between functional testing and sensitivity testing requirements in accordance with 2012 NFPA 101 §9.6.1.5 and NFPA 72:2010 §14.4.5. The updated program specifies that sensitivity testing must be performed on all smoke detectors annually per NFPA 72 requirements, separate from routine functional testing. The fire alarm service contract was amended to explicitly require sensitivity testing documentation for all smoke detection devices. The program includes a tracking system to ensure sensitivity testing is completed for all detectors and properly documented with test results, detector locations, and any corrective actions taken. Administrator immediately provided education fire alarm sensitivity testing for all smoke detectors. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Safety Committee reviews fire alarm system inspection and testing records monthly to verify compliance with sensitivity testing requirements. The Director of Maintenance maintains a tracking log of all smoke detector sensitivity testing with completion dates, test results, and vendor documentation. The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting quarterly for 2 quarters. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	07/08/2026
K0914 SS = F Bldg. 01	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of	K0914	How the corrective action will be accomplished for the residents affected by the deficient practice: No residents were identified nor affected by not ensuring nonhospital grade outlets used at patient bed locations were not Inspected. All non-hospital grade electrical receptacles at patient bed locations on the second floor were immediately inspected by the Director of Maintenance on 5/26/26. Each receptacle was tested for physical integrity, grounding continuity, polarity, and blade retention in accordance with 42 CFR. in accordance with NFPA 99: 2012 Edition, Sections 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4.	07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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
K0914 SS = F Bldg. 01	Continued from page 2 less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation, interview and record review on 05/18/2026 and 05/19/2026 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6), it was determined the facility failed to ensure non hospital grade outlets used at patient bed locations were Inspected, Tested and Maintained (ITM) in accordance with NFPA 99: 2012 Edition, Sections 6.3.3.2, 6.3.3.2.1 to 6.3.3.2.4. This deficient practice had the potential to affect 57 of 110 residents and was evidenced by the following: Observations on 05/18/2026 of the second floor residents rooms revealed the electrical receptacles at patient bed locations were not hospital grade. In an interview at the time the U.S. FO and U.S. FOIA confirmed the observation. Record review on 05/19/2026 at 12:10 PM of the electrical inspection reports revealed, there was no report of the receptacles at patient bed locations being tested for physical integrity, grounding continuity, polarity and blade retention in the last 12 months. No further documentation was provided. In an interview at the time the U.S. FO and U.S. FOIA confirmed the record review. The facility's U.S. FOIA (b)(6) U.S. FO and U.S. FOIA were informed of the deficient practice at the Life Safety Code exit conference on 05/19/2026 at 2:28 PM. N.J.A.C. 8:39-31.2(e) NFPA 99	K0914	Continued from page 2 How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affacted by this practice. Measures or systemic changes made to ensure no recurrence: The Director of Maintenance revised the Non-Hospital Grade Receptacle, Testing, and Inspection audit sheet to include, physical integrity, grounding continuity, polarity, and blade retention. Administrator immediately provided education on testing of all non-hospital grade outlets. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Safety Committee will review the audit sheets from the inspection and testing records monthly to verify compliance physical integrity, grounding continuity, polarity and blade retention. The results of the monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting quarterly for 2 quarters. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	07/08/2026
K0222 SS = E Bldg. 01	Egress Doors CFR(s): NFPA 101	K0222	How the corrective action will be accomplished for the residents affected by the deficient practice: No residents were identified nor affected by not	07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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
K0222 SS = E Bldg. 01	Continued from page 3 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 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	K0222	Continued from page 3 having a visible sign with letters not less than 1 inch high on contrasting background that reads as follows shall be located on the door leaf adjacent to the releasing device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, in accordance with NFPA 101:2012 Edition, Section 7.2.1.6.1 (4). How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this practice. Measures or systemic changes made to ensure no recurrence: On 5/22/2026 the Director of Maintenance installed a clearly visible sign with lettering no less than one inch in height on a contrasting background that reads: “PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS.” Additionally, the Director of Maintenance revised the Door Inspection Audit Tool to include verification of “Delayed Egress Door Inspection Signage” as a required component of the facility’s comprehensive Door Inspection and Maintenance Program. This measure will ensure ongoing monitoring and compliance with delayed egress door signage requirements. Administrator immediately provided education on having visible signage on delayed egress doors. The facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur by: The Maintenance Director, or designee, will conduct audits of all exit doors weekly for four consecutive weeks, followed by continued weekly audits for an additional four weeks to ensure sustained compliance. Audit results will be reviewed and presented by the Maintenance Director to the Quality Assurance and Performance Improvement (QAPI) Committee during the monthly meeting. The Committee will evaluate compliance trends, identify any areas requiring corrective action, and determine whether additional interventions are necessary to achieve and maintain 100% compliance.	07/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 05/21/2026

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

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K0222 SS = E Bldg. 01	Continued from page 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 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 STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/18/2026 in the presence of the U.S. FOIA (b)(6) and U.S. FOIA (b)(6), it was determined the facility failed to ensure delayed egress locking systems were provided with a readily visible sign with letters not less than 1 inch high on contrasting background that reads as follows shall be located on the door leaf adjacent to the releasing device in the direction of egress: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, in accordance with NFPA 101:2012 Edition, Section 7.2.1.6.1 (4). This deficient practice had the potential to affect 37 of 110 residents and was evidenced by the following: Observations at 11:25 AM revealed, the exterior exit door for the south stairway (C) was equipped with delayed egress hardware and did not have a required instructional sign stating: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. In an interview at the time the U.S. FO and U.S. FOIA confirmed the observation. The facility's U.S. FOIA (b)(6) U.S. FO and U.S. FOIA were informed of the deficient practice at the Life Safety Code exit conference on 05/19/2026 at 2:28 PM. N.J.A.C. 8:39-31.2(e)	K0222		07/08/2026

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 05/21/2026

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EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE , WAYNE, New Jersey, 07470**

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E0000	Initial Comments An Emergency Preparedness survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/19/2026. Excel Care at Wayne was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Requirements for Long Term Care Facilities.	E0000		05/22/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315103	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **07/29/2026**

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
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/29/2026 in relation to the 05/21/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(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.	K0000		

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.

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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 07/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0000	Initial Comments The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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.

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