STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE WAYNE, NJ 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
F 000	INITIAL COMMENTS Complaint #s NJ00164324, NJ00159354, NJ00159144, NJ00155340, NJ00160076, NJ00163192, NJ00160703, NJ00164427, NJ00163988 STANDARD SURVEY: 9/21/23 CENSUS: 106 SAMPLE SIZE: 25 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.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's	F 640		9/22/23

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

Electronically Signed | 10/05/2023

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

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F 640	Continued From page 1 assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed electronically transmit the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment for	F 640	1. Residents affected: #103, #92, #31, #76. The following corrective action will be taken for those residents found to be affected: MDS Coordinator will review all admissions/readmissions, including discharges during daily clinical reporting.	

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F 640	Continued From page 2 5 of 25 residents, (Resident #103, #92, #31, #76, and #107) reviewed for resident assessment. The deficient practice was evidenced by the following: 1. Resident #103 was observed to have a Ex.Order 26.4(b) MDS of EX Order 26.4B1 and was due to be transmitted no later than EX Order 26.4B1 The Ex.Order 26.4(b) MDS was not transmitted until EX Order 26.4B1 2. Resident #92 was observed to have an Entry MDS of EX Order 26.4B1 and was due to be transmitted no later than EX Order 26.4B1 The Ex.Order 26.4(b) MDS was not transmitted until EX Order 26.4B1 3. Resident #31 was observed to have an Admission MDS of EX Order 26.4B1 and was due to be transmitted no later than EX Order 26.4B1. The Ex.Order 26.4(b) MDS was not transmitted until er 26.4B1 4. Resident #76 was observed to have an Admission MDS of EX Order 26.4B1 and was due to be transmitted no later than EX Order 26.4B1 The Ex.Order 26.4(b) MDS was not transmitted until r 26.4B1. 09/14/23 09:47 AM, the surveyor interviewed the facility's Registered Nurse (RN) MDS Coordinator who was responsible for completing and transmitting the MDS assessments who agreed that the above MDS assessments were transmitted late due to transition of the system in April this year.	F 640	No negative outcomes were observed. 2. All residents have the potential to be affected. 3. The following Measures and systemic changes will be put in place to ensure the deficient practice will not recur: MDS Coordinator will report weekly the MDS submissions and submit the validation reports to the Vice President of Clinical Reimbursement and run the monthly report for missing OBRA assessment(s) at the end of each month. The Vice President of Clinical Reimbursement will audit monthly the MDS submissions for compliance. 4.The MDS Coordinator was in-serviced on the RAI (Resident Assessment Instrument) process, with focus on electronically transmitting the MDS within 14 days of completing the resident's assessment. 5. The submissions status for MDS will be discussed during 24 hour morning meeting. 6. The following programs will be put into place to monitor the continued effectiveness of the systemic changes: MDS Coordinator will QAPI quarterly for review /recommendations x12 months the MDS submission report and quantify the total number submissions each month. The outcomes will be reviewed monthly, with a QAPI quarterly for review /recommendations x 12 months. The Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator, shall review the audit to ensure compliance.	

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F 640	Continued From page 3 5. The surveyor reviewed the closed medical records for Resident #107. On 9/21/23 at 9:38 AM, the surveyor reviewed the Progress Notes which revealed that the resident was discharged to the [redacted] on [redacted] The surveyor then reviewed the MDS assessment submissions which revealed that there was no MDS submission of a discharge assessment completed. In addition, the electronic records indicated that the MDS discharge assesssment was 19 days overdue. On 9/20/23 at 1:04 PM, the survey team met with the LNHA and DON to review the MDS records for Resident #107. The DON stated that she would check with the MDS Coordinator. On 9/21/23 at 9:30 AM, the surveyor interviewed the DON who stated that the MDS discharge was completed for Resident #107. The DON provided the surveyor with a CMS Submission Report MDS 3.0 NH Final Validation Report which reflected that Resident #107's discharge MDS had a "Target Date" of [redacted] and the "Record Submitted Late: Submission date is more than 14 days after."	F 640		
F 755	NJAC 8:39-11.1 Pharmacy	F 755		9/25/23

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F 755 SS=D	Continued From page 4 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(g). 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	F 755	1. Residents affected: #1, # 2, #3, #4. The following corrective action will be	

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F 755	Continued From page 5 provide pharmaceutical services in accordance with professional standards to accurately document the administration of physician ordered medications in the electronic administration record by one (1) of three (3) nurses observed administering medications. The deficient practice occurred for four (4) unsampled residents (#1, #2, #3, and #4). 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." This deficiency was evidenced by the following:	F 755	taken for those residents found to be affected: DON/ADON/Pharmacy Consultant will continue to conduct nursing competency on medication administration quarterly. All nursing staff were in-serviced on 9/25/2023 and will continue with monthly in-services. No negative outcomes were observed. 2. All residents have the potential to be affected. 3. The following Measures and systemic changes will be put in place to ensure the deficient practice will not recur: DON/ADON will monitor the documentation compliance of the EMAR on PCC daily and review the compliance with Unit Managers at least weekly on an ongoing basis for progress and to assure medication documentation administration is in compliance as ordered by physician. 4. The following programs will be put into place to monitor the continued effectiveness of the systemic changes: DON/ADON/UMs/Pharmacy Consultant will QAPI quarterly for review /recommendations x12 months. The results will be logged and outcomes will be reviewed monthly, with a QAPI quarterly for review /recommendations x 12 months. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audit to ensure compliance. This POC is being filed in accordance with state and federal requirements.	

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F 755	Continued From page 6 On 9/12/23 at 9:16 AM, the surveyors, observed the Licensed Practical Nursing (LPN) at the medication cart. The LPN stated that he had already prepared medications for a resident and was just about to go and administer the medications. The LPN then left the medication cart and entered a resident's room. On 9/12/23 at 9:22 AM, the Unit Manager (UM)/LPN approached the surveyors at the medication cart and stated that she was completing the medication pass because she had been helping the LPN that day. On 9/12/23 at approximately 9:22 AM to 9:54 AM the surveyors observed the morning medication pass with the UM/LPN. On 9/12/23 at 9:54 AM, at the medication cart, the surveyors interviewed the UM/LPN who stated that the morning medication pass was complete for that medication cart. The surveyors with the UM/LPN reviewed the electronic medication administration record (EMAR) which revealed resident's names highlighted in yellow and red. The UM/LPN explained that the resident's names highlighted in yellow meant that something was due. The UM/LPN further explained that the resident names in yellow still needed documentation to be completed for either a pain assessment or behavior monitoring which could be completed throughout the 7 AM to 3 PM shift but the morning medications had been administered. The UM/LPN then stated that the resident names in red meant that something was overdue. The UM/LPN could not speak to why four (4) resident names were highlighted in red on the EMAR.	F 755		

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F 755	Continued From page 7 At that time, the surveyors, with the UM/LPN, reviewed the EMAR for the four (4) unsampled resident names that were highlighted in red. The UM/LPN acknowledged that the four (4) unsampled residents each had medications with an administration time of 8AM highlighted in red which meant that the 8AM medications were not administered and were out of the administration time which should have been administered one hour before 8 AM or one hour after 8 AM. In addition, the UM/LPN acknowledged that there were 9 AM medications that were highlighted in yellow which meant that those medications were due to be administered to the four unsampled residents. The UM/LPN stated that she was helping with the medication pass that morning because the LPN had a personal matter that he had to attend to that day. The UM/LPN stated that she would have to check with the LPN to see if the medications for the four unsampled residents were administered. On 9/12/23 at 9:57 AM, the surveyors, with the LPN and the UM/LPN, reviewed the EMARs for the four unsampled residents. The LPN stated that for unsampled resident #1 and #2, he had administered the 8AM and 9AM medications but had not signed the EMAR. The LPN then stated for unsampled residents #3 and #4, he had administered the 8AM medications but had not signed the EMAR. The LPN added that for unsampled residents #3 and #4 he had not yet administered the 9AM medications and was about to do that. The UM/LPN stated that the EMAR was to be signed immediately following administration of a medication and was unaware that there were still residents who had to have	F 755		

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F 755	Continued From page 8 their 9AM medications administered. The UM/LPN and LPN acknowledged that by not signing the EMAR immediately following administration of medications could be interpreted by another nurse that the medications were not administered and could have been administered twice. The surveyor reviewed the medical records for unsampled residents #1, #2, #3 and #4. A review of the EMAR for unsampled resident #1 had one (1) medication, EX Order 26.4B1 chewable tablet, with an administration time of 8AM and four (4) medications with an administration time of 9 AM; EX Order 26.4B1 EX Order 26.4B1 According to the LPN, the 8AM and 9AM medications were administered and were not signed on the EMAR. A review of the Order Summary Report (OSR) for unsampled resident #1 reflected physician's orders (PO) for the medications listed above. A review of the EMAR for the unsampled resident #2 had one (1) medication, EX Order 26.4B1	F 755		

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F 755	Continued From page 9	F 755		

EX Order 26.4B1 [redacted]

According to the LPN, the 8AM and 9AM medications were administered and were not signed on the EMAR.

A review of the OSR for unsampled resident #2 reflected PO for the medications listed above.

A review of the EMAR for the unsampled resident #3 had two (2) EX Order 26.4B1 [redacted] with the administration time of 8AM. According to the LPN, the 8 AM medications were administered and were not signed on the EMAR as administered.

A review of the OSR for unsampled resident #3 reflected PO for the medications listed above.

A review of the EMAR for the unsampled resident #4 had one (1) medication, EX Order 26.4B1 [redacted], with an administration time of 8AM. According to the LPN, the 8 AM medication was administered and was not signed on the EMAR as administered.

A review of the OSR for unsampled resident #4 reflected PO for the medication listed above.

On 9/12/23 at 11:45 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated that the LPN had a personal issue

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F 755	Continued From page 10	F 755		

that day and the UM/LPN was helping to pass the medications so that there was no delay. The DON added that the UM/LPN should have coordinated with the LPN to know which residents still needed medications to be administered. The DON acknowledged that the EMAR should be documented immediately following the administration of medications to prevent any discrepancy. The DON stated that the UM/LPN was responsible for the medication pass because the LPN had a personal issue that day.

A review of a Medication Administration Observation dated 5/13/23 for the LPN completed by the Consultant Pharmacist (CP) and provided by the DON reflected that the LPN had followed that "Medications are documented as per regulation." And that "Nurses's initials are present for each scheduled time of medication administration per documentation on MAR after medication is administered." The form indicated that the LPN had an accuracy rate of 100%.

On 9/15/23 at 1:05 PM, the surveyor interviewed the CP via the telephone. The CP stated that she had completed a medication observation with LPN, and he had done well. The CP stated that the nurses were to sign the EMAR immediately after administration of medications. The CP added that if the EMAR was not signed there was the possibility of the nurses not knowing whether a medication was administered already and administering the medication again. The CP added that she had done in-services in the past for the nurses and used a handout with the medication pass techniques to follow.

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F 755	Continued From page 11 A review of the "Administration of Medication" forms provided by the CP that were used for an in service which reflected "Sign the EMAR/MAR after the medication has been administered." On 9/18/23 at 10:45 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that she educates the nurses on medication pass techniques, along with the CP and completes competencies. The ADON stated that the protocol for medication administration was that the nurses were to "give and sign" meaning that the nurses were to sign the EMAR immediately after administration of medications. The ADON acknowledged that if the nurses had not signed the EMAR after administration that could lead to discrepancies and possible double dosing. A review of a medication administration in-service dated 7/13/23 completed by the facility that the LPN had attended reflected that "All nurses make sure that meds are given on time and must check name of resident, right dose, right time, right drug, right route and sign that given after meds taken." A facility policy dated 2/2023 for "Medication Administration" reflected that "It is the policy of the facility to provide appropriate medication administration to residents to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with State and Federal regulation." In addition, the policy reflected that the procedure was "Document medication taken or refused by resident."	F 755		

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F 755	Continued From page 12 NJAC 8:39-11.2(b), 29.2 (a)(d)	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to sanitize and air-dry steam table pans and sheets pans in a manner to prevent microbial growth and c.) failed to maintain the kitchen equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following:	F 812	1. Residents affected: All Residents. The following corrective action will be taken for those residents found to be affected: Food Service Director will review regularly and check that dented cans are not in rotation, air drying policy is reviewed regularly, stove and convection oven cleaned weekly, and food storage containers are all dated. No negative outcomes were observed. 2. All residents have the potential to be affected.	9/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE WAYNE, NJ 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
F 812	Continued From page 13 On 9/13/23 at 10:49 AM, in the presence of the Food Service Director (FSD) the surveyor observed the following: 1. In the dry storage area, the surveyor observed a random sampling of dented cans which were in rotation for use. The surveyor observed the following: - One #10 sized cans of diced pears with 2-inch sized dent on the upper lip of the can, - One #10 sized can of diced pears with 1-inch sized dent on the upper lip of the can, The FSD stated that these cans are in rotation for use and should not have dents. 2. In the food preparation area, on shelf, the surveyor observed two sheet pans stacked with soapy water between them. The FSD stated should not be soapy or stacked when wet and that they should be air dried before stacking. 3. In the food preparation area, the surveyor observed four of six burner stove tops were soiled with a thick grease-like buildup. The surveyor also observed that five oven knobs were soiled with a cream-colored food substance, and one of three convection knobs soiled with a cream colored substance. 4. In the food preparation area, the surveyor observed food storage containers. The surveyor observed a container of bread-crumbs and food thickener with no dates on the items. The surveyor also observed another container with	F 812	3. The following Measures and systemic changes will be put in place to ensure the deficient practice will not recur: Food Service Director In-Serviced Dietary Department on 9/22/2023 and provided copy of policy and procedure. 4. The following programs will be put into place to monitor the continued effectiveness of the systemic changes: Food Service Director will QAPI quarterly for review /recommendations x12 months. The outcomes will be reviewed monthly, with a QAPI quarterly for review /recommendations x 12 months. This POC is being filed in accordance with state and federal requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE WAYNE, NJ 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
F 812	Continued From page 14 white powdered substance which had no no label and no date. The FSD stated that was sugar but that it should have been labeled and dated. On 9/13/23 at 1:10 PM Discussed concerns in kitchen with Administrator and Director of Nursing. A review of the Air Drying policy, dated 1/2023 revealed, "All items must be inverted after cleaning and sanitizing and air dry all items in designated station." NJAC 8:39-17.2(g)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061614	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 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) COMPLETE DATE
S 000	Initial Comments STANDARD AND COMPLAINT STATE SURVEY - 9/21/23 Complaint# NJ00155340; NJ00164427 SAMPLE SIZE: 25 CENSUS: 106 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint# NJ00155340, and NJ00164427 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident	S 560	1. Residents affected: All Residents. The following corrective action will be taken for those residents found to be affected: DON/Designee will review staffing needs with staffing coordinator regularly and check that staff par levels meet the required ratios. DON/Designee will	9/22/23

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

Electronically Signed — 10/05/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061614	A. BUILDING: _____ B. WING _____	C 09/21/2023

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S 560	Continued From page 1 ratios 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: (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 the 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	S 560	continue to advertise staffing needs through recruitment agencies. No negative outcomes were observed. 2. All residents have the potential to be affected. 3. The following Measures and systemic changes will be put in place to ensure the deficient practice will not recur: DON/Designee will review staffing needs with staffing coordinator at least weekly on an ongoing basis for progress and to assure mandatory staffing is maintained. DON/Designee will continue to maintain a recruitment & hiring log, to track all CNAs applicants and outcomes. Facility to continue utilizing agency to increase staffing. Facility to continue post open C.N.A. position on job sites and job fairs. Facility to continue to continue to offer incentive referral bonus and sign bonuses. Current CNAs Rate is above market rate. 4. The following programs will be put into place to monitor the continued effectiveness of the systemic changes: DON/Designee will discuss staffing recruitment and retention plan monthly QAPI quarterly for review /recommendations x12 months. The recruitment log of all applicants and outcomes will be reviewed monthly, with a QAPI quarterly for review /recommendations x 12 months. This POC is being filed in accordance with state and federal requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061614	A. BUILDING: _____ B. WING _____	C 09/21/2023

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S 560	Continued From page 2 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 on 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 the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" 1. For the week of Complaint staffing from 04/10/2022 to 04/16/2022, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: - On 04/10/22 had 9 CNAs for 99 residents on the day shift, which required at least 12 CNAs. - On 04/10/22 had 6 total staff for 99 residents on the overnight shift, which required at least 7 total staff. - On 04/11/22 had 10 CNAs for 99 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 the day shift, which required at least 12 CNAs. - On 04/12/22 had 9 CNAs for 99 residents on the day shift, which required at least 12 CNAs. - On 04/13/22 had 10 CNAs for 99 residents on the day shift, which required at least 12 CNAs. - On 04/14/22 had 8 CNAs for 99 residents on the day shift, which required at least 12 CNAs. - On 04/15/22 had 11 CNAs for 98 residents on the day shift, which required at least 12 CNAs. - On 04/16/22 had 6 CNAs for 98 residents on the day shift, which required at least 12 CNAs. 2. For the week of Complaint staffing from 05/08/2022 to 05/14/2022, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts and deficient in total staff for residents on 4 of 7 overnight shifts as follows: -On 05/08/22 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -On 05/08/22 had 5 total staff for 104 residents on the overnight shift, which required at least 7 total staff. - On 05/09/22 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 05/10/22 had 11 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 05/11/22 had 9 CNAs for 104 residents on the day shift, which required at least 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 4 - On 05/12/22 had 12 CNAs for 106 residents on the day shift, which required at least 13 CNAs. - On 05/12/22 had 7 total staff for 106 residents on the overnight shift, which required at least 8 total staff. - On 05/13/22 had 10 CNAs for 106 residents on the day shift, which required at least 13 CNAs. - On 05/13/22 had 5 total staff for 106 residents on the overnight shift, which required at least 8 total staff. - On 05/14/22 had 8 CNAs for 104 residents on the day shift, which required at least 13 CNAs. -On 05/14/22 had 6 total staff for 104 residents on the overnight shift, which required at least 7 total staff. 3. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 7 of 7-day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: - On 07/30/23 had 8 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 07/31/23 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/01/23 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/02/23 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - 08/03/23 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

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S 560	Continued From page 5 - On 08/04/23 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/04/23 had 6 total staff for 104 residents on the overnight shift, which required at least 7 total staff. -On 08/05/23 had 10 CNAs for 103 residents on the day shift, which required at least 103 CNAs. 4. For the 2 weeks of staffing prior to the survey from 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 12 of 14-day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts and deficient in total staff for residents on 4 of 14 overnight shifts as follows: - On 08/20/23 had 11 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/20/23 had 6 CNAs to 14 total staff on the evening shift, which required at least 7 CNAs. - On 08/20/23 had 6 total staff for 105 residents on the overnight shift, which required at least 7 total staff. - On 08/21/23 had 10 CNAs for 105 residents on the day shift, which required at least 13 CNAs. - On 08/22/23 had 12 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/23/23 had 10 CNAs for 104 residents on the day shift, which required at least 13 CNAs. - On 08/23/23 had 6 total staff for 104 residents on the overnight shift, which required at least 7 total staff. - On 08/24/23 had 11 CNAs for 103 residents on	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061614	A. BUILDING: _____ B. WING _____	C 09/21/2023

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S 560	Continued From page 6 the day shift, which required at least 13 CNAs. - On 08/25/23 had 11 CNAs for 103 residents on the day shift, which required at least 13 CNAs. -On 08/26/23 had 8 CNAs for 103 residents on the day shift, which required at least 13 CNAs. - On 08/27/23 had 7 CNAs for 102 residents on the day shift, which required at least 13 CNAs. -On 08/28/23 had 11 CNAs for 102 residents on the day shift, which required at least 13 CNAs. -On 08/29/23 had 6 total staff for 103 residents on the overnight shift, which required at least 7 total staff. -On 08/31/23 had 11 CNAs for 102 residents on the day shift, which required at least 13 CNAs. - On 09/01/23 had 8 CNAs for 106 residents on the day shift, which required at least 13 CNAs. -On 09/01/23 had 7 total staff for 106 residents on the overnight shift, which required at least 8 total staff. -On 09/02/23 had 9 CNAs for 105 residents on the day shift, which required at least 13 CNAs. 5. For the week of Complaint staffing from 05/21/23 to 05/27/2023 for the 09/21/2023 Standard survey with Complaints. The facility was deficient in CNA staffing for residents on 7 of 7-day shifts and deficient in total staff for residents on 4 of 7 overnight shifts as follows: - On 05/21/23 had 8 CNAs for 110 residents on the day shift, which	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 7 required at least 14 CNAs. - On 05/21/23 had 6 total staff for 110 residents on the overnight shift, which required at least 8 total staff. - On 05/22/23 had 11 CNAs for 109 residents on the day shift, which required at least 14 CNAs. - On 05/23/23 had 10 CNAs for 109 residents on the day shift, which required at least 14 CNAs. - On 05/24/23 had 10 CNAs for 109 residents on the day shift, which required at least 14 CNAs. -On 05/24/23 had 6 total staff for 109 residents on the overnight shift, which required at least 8 total staff. - On 05/25/23 had 9 CNAs for 109 residents on the day shift, which required at least 14 CNAs. - On 05/25/23, we had 7 CNAs for 109 residents on the overnight shift, which required at least 8 total staff. - On 05/26/23 had 10 CNAs for 109 residents on the day shift, which required at least 14 CNAs. - On 05/27/23 had 10 CNAs for 111 residents on the day shift, which required at least 14 CNAs. -On 05/27/23 had 5 total staff for 111 residents on the overnight shift, which required at least 8 total staff. On 9/20/23 at 10:10 AM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing. The administrator stated that they are aware of the lack of staffing and the ratio they need for the aide, but the facility continuously hires staff, has an open house, and has sign-on bonuses for the new hires. The	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 8 facility provides in-house training for the aides but after getting all their licenses, they leave the job. The facility has a contract with another agency to fill in the position.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315103 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0640	Correction	ID Prefix F0755	Correction	ID Prefix F0812	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	09/22/2023	LSC	09/25/2023	LSC	09/22/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061614 Y1	A. Building B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/22/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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LSC		LSC		LSC	
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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/21/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	**296 HAMBURG TURNPIKE** **WAYNE, NJ 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
E 000	Initial Comments . An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/08/2023. The facility was found to be in compliance with 42 CFR 483.73. .	E 000		
K 000	INITIAL COMMENTS . A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/08/23 and was found to be in noncompliance 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. Excel Care at Wayne is a two-story building with a basement that was built in 1960's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 50 % of the building as per the Maintenance Director. The current occupied beds are 106 of 118. .	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance	K 211		9/25/23

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

Electronically Signed | 10/05/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**09/21/2023**

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K 211	Continued From page 1 with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the entrance to an enclosed usable space was not from within a stairway enclosure and the means of egress was maintained free of all obstructions in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 7.2.2.5.3 and 7.2.2.5.3.2. This deficient practice had the potential to affect 106 residents. Findings Include: An observation on 09/08/23 at 12:10 PM and 12:25 PM revealed two of two stairways had storage rooms at the bottom of both stairways, located in the basement. Access to the storage rooms was from within the stairways. At the time of the observation, the Administrator confirmed the storage rooms in the stairways and informed they had been there for a long time. NJAC 8:39-31.2(e) .	K 211	1. The Closet in the West Stairwell and the Closet in the North Stairwell (both with a sprinkler head and auto closer) were immediately deconstructed from being a closet with the removal of the doors on Sunday, 9/10/2023. 2. No residents have the potential to be affected from the former closets that are located in Non-resident areas in the lower level. 3. Maintenance has been in-serviced on means of egress. 4. The Administrator will conduct walking rounds weekly for 1 quarter to ensure that means of egress is in compliance. 5. All findings will be implemented and the corrective action evaluated for its effectiveness. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audit on a Quarterly basis to ensure compliance. This POC is being filed in accordance with state and federal requirements.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345		9/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 345	Continued From page 2 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 REQUIREMENT is not met as evidenced by: . Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity of the smoke detectors was completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 106 residents. Findings include: A document review of the facility binder for the calendar year 2023, provided by the Administrator, revealed the fire alarm "Inspection and Testing Reports" dated 04/03/23 had no reference to a smoke detection sensitivity test. An observation of the facility smoke detectors on 09/08/23 from 12:10 PM to 1:45 PM revealed smoke detectors were in the corridors at the smoke barriers, in all sleeping rooms, and other concealed areas throughout the building. During an interview on 09/08/23 at 1:40 PM, the Administrator stated he contacted the fire alarm company who stated they had sent a proposal in	K 345	1.The Fire Alarm System (Control Panel EST iO500) underwent a Smoke Sensitivity Test on Monday, 9/11/2023. The Test "Passed" and the Report submitted on Friday, 9/15/2023. 2. All residents have the potential to be affected by the deficient practice of not have a smoke sensitivity test every two years. 3. Maintenance has been in-serviced on Fire Alarm System Testing. 4. The Administrator will track the compliance of the Smoke Sensitivity Testing Every Two Years as Required by NFPA 70 and NFPA 72. 5. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audits on a quarterly basis to ensure compliance. This POC is being filed in accordance with state and federal requirements.	

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	315103	A. BUILDING **01** B. WING _____	**09/21/2023**

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

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K 345	Continued From page 3 2021 and the facility had declined the proposal. The Administrator confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=F	. Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: . Based on observation and interview the facility failed to ensure sprinklers were installed under fixed obstructions over 4 ft (1.2m) wide in	K 351	1. Sprinkler Head Under HVAC Unit in Lower Level Storage Room was Installed on Thursday, 9/14/2023. 2. All residents have the potential to be	9/25/23

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	315103	A. BUILDING **01** B. WING _____	**09/21/2023**

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K 351	Continued From page 4 accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (2010 Edition) section 8.5.5.3.1. This deficient practice had the potential to affect all 106 residents. Findings include: An observation on 09/08/23 at 12:13 PM revealed the Heating Ventilation Air Conditioning Unit, located in the basement by stairway one, was larger than four feet, was hanging from the ceiling and did not have a sprinkler head installed under the unit. At the time of the observation, the Administrator confirmed a sprinkler head was missing and stated the sprinkler contractor advised the facility should install a sprinkler head under the unit, but it was only a suggestion. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25 .	K 351	affected by the deficient practice of automatic sprinkler coverage for area larger than four feet under HVAC unit (fixed obstruction). 3. Maintenance was in-serviced on sprinkler system coverage under fixed obstructions over four feet. 4. The Administrator will conduct walking rounds weekly for one quarter to ensure no areas under fixed obstructions over four feet are not deficient. 5. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audits on a quarterly basis to ensure compliance. This POC is being filed in accordance with state and federal requirements.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are	K 761		11/20/23

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K 761	Continued From page 5 maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: . Based on observation and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 106 residents. Findings include: AN observation of the facility's fire doors on 09/08/23 from 12:10 PM to 1:45 PM revealed the doors lacked the required inspection tags on the doors after completed inspections. During an interview at the time of the observation, the Administrator confirmed the fire doors were not inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 .	K 761	1. Maintenance was in-serviced on Maintenance, Inspection and Testing of Door. 2. Maintenance will conduct walking rounds weekly to ensure all doors have appropriate tags for rating and log results monthly x12 months. 3. All residents have the potential to be affected by the deficient practice of not having fire doors inspected annually. 4. The Administrator will monitor the presence of appropriate tags for one quarter and monitor annual maintenance. 5. This plan will be implemented and the corrective action evaluated for its effectiveness. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audit to ensure compliance. This POC is being filed in accordance with state and federal requirements.	
K 914 SS=F	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	K 914		9/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315103	A. BUILDING **01** B. WING _____	**09/21/2023**

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

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K 914	Continued From page 6 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 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 REQUIREMENT is not met as evidenced by: . Based on observation, interview, and document review, the facility failed to ensure electrical outlet testing was conducted annually on the electrical system in accordance with NFPA 99 (2012 edition) Health Care Facilities Code section 6.3.4.1.3. This deficient practice had the potential to affect all 106 residents. Findings include: A document review of the Fire Safety Folder for 2023, provided by the Administrator, revealed the electrical outlet testing was not completed on the electrical outlets. During an interview at 1:55 PM on 09/08/23, the Administrator confirmed that the electrical outlet testing was not completed on the electrical	K 914	1.Electrical Outlet Testing was Confirmed to be Completed on 9/14/2023 by Fairways Management, LLC when Electrical Plans were approved by DCA on 6/7/2023 and Subcode Approval for Permit was Approved on 8/15/2023. 2. A electrical inspection was completed for ExcelCare Wayne and all electrical receptacles, specifically in patient care rooms are in working order and tested. Electrical Permit # 23-4320 was issued on 8/17/2023. 3. All residents have the potential to be affected by the deficient practice of not having an annual electrical inspection. 4. Maintenance was in-serviced on Electrical Systems - Maintenance and Testing. 5. The Administrator or Designee will	

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K 914	Continued From page 7 system. NJAC 8:39-31.2(e) NFPA 99 .	K 914	monitor weekly for one month after the annual electrical inspection that all electrical outlets on visual inspection are in working order. 6. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audits on a quarterly basis to ensure compliance. This POC is being filed in accordance with state and federal requirements.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		9/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 8 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: . Based on record review and interview, the facility failed to ensure the three-year load bank test was completed on the existing emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 106 residents. Findings include: A document review of the generator reports for 2022 and 2023 provided by the Administrator revealed a three-year load bank test had not been completed for the emergency generator. During an interview at 1:55 PM on 09/08/23 the Administrator confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	1. Generator (Kohler Generator / Model # 150RE0ZJF / Spec. GM 81645GAI / Serial # SGM32H2TV) underwent a 3-year load bank test on Tuesday, 9/12/2023. 2. All residents have the potential to be affected by the deficient practice of not having a 3-year load bank test on the generator. 3. Maintenance was in-serviced on Essential Electric System Maintenance and Testing. 4. The Administrator will track the completion of a 3-year load bank test on the generator every 3 years. 5. This plan of correction is integrated into the Quality Assurance Performance Improvement (QAPI) program. The Quality Assurance Performance Improvement Committee, chaired by the Administrator, shall review the audits on a quarterly basis to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 9	K 918	This POC is being filed in accordance with state and federal requirements.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315103 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/21/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCEL CARE AT WAYNE	296 HAMBURG TURNPIKE WAYNE, NJ 07470

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	09/25/2023	LSC K0345	09/25/2023	LSC K0351	09/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0761	11/20/2023	LSC K0914	09/25/2023	LSC K0918	09/25/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/21/2023	☐ YES ☐ NO