STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 10/25/2022 Census: 66 Sample: 17 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 accurately code a resident's oral/dental status on the resident's most recent quarterly and annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care. This deficient practice was identified for 1 of 20 residents, (Resident #10) reviewed for MDS assessments related to dental care services and was evidenced by the following:	F 641	MDS Coordinators made corrections to the MDS on section L0200 for resident #10. Resident #10 had no negative outcomes and was seen by Dentist and refused further interventions. MDS Coordinators examined all residents dental status using section L of the MDS. MDS Coordinators compared their findings during the dental assessment to the most recent MDS and verified that no	10/31/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/04/2022

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F 641	Continued From page 1 On 10/12/2022 at 12:55 PM, the surveyor observed Resident #10 in bed in his/her room watching television. The surveyor further observed that the resident's teeth were brown and discolored. The resident's front teeth were chipped and deteriorated. The surveyor asked the resident if he/she had soreness in their mouth and pain or discomfort when eating. Resident #10 stated that he/she did not have pain while eating. On 10/18/22 at 11:39 AM, The surveyor observed the resident in bed, chewing on the corner of his/her bed blanket. A review of the Admission Record revealed the resident was admitted to the facility on [redacted] with a diagnosis that included [redacted] The resident is a recipient of [redacted] A review of the Resident Evaluation with Covid-19 Screen, dated 07/30/2020 at 21:15, it revealed under section E. Oral /Dental and Hearing/Speech/Vision/Diet with #4 was checked as: EX Order 26 § 4b1 [redacted] A review of the Quarterly MDS, dated 04/14/2022, revealed the resident had Brief Interview for Mental Status (BIMS), score of [redacted], [redacted]. It further revealed under section L 0200, Oral/Dental status that no boxes were checked with any issues. A review of the Annual MDS, dated 07/28/2022 revealed the resident had BIMS, score of [redacted], EX Order 26 § 4b1. It further revealed under	F 641	additional corrections needed to be made . All resident with dental issues have the potential to be affected. DON or Designee educated Nurses on the importance of performing dental exam during admission assessment, Quarterly and as needed and to document if a resident refuses further intervention. The MDS Coordinators were educated on reviewing the admission assessment, completing their own assessment and accurately completing the MDS assessment Section L 0200 of Oral/Dental Status Director of Nursing or designee will review weekly for 4 weeks and bi weekly for 12 weeks starting October 24th 2022 for all resident assessments to ensure accuracy and reflection of the resident's status. Administrator will analyze audits for patterns and trends and report results to the QA committee monthly for 3 months. plan will be adjusted based on results and data.	

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F 641	Continued From page 2	F 641		

section L0200, Oral/Dental status that "none of the above were present."

A complete review of the resident's medical record did not reveal documentation that the resident was offered and refused dental care services.

The surveyor conducted an interview with the Registered Nurse (RN) MDS coordinator, on 10/20/22 at 12:08 PM. The MDS Coordinator stated he had 13 years of experience performing MDS assessments and explained that he looked at all the documentation across the tabs, then based on his findings, he would interview the staff and the resident. The surveyor asked the RN MDS Coordinator if he assessed the resident's dentition during his assessment. The MDS Coordinator stated that he interviewed the resident and did not identify areas of concern regarding the resident's dentition.

On 10/20/2022 at 01:34 PM, the above concern was discussed with the Assistant Director of Nursing (ADON) and Licensed Nursing Home Administrator (LNHA).

A review of the facility's Routine Dental Care policy, revised April 2022, provided by the LNHA on 1/19/2022, indicated:
1.) Nursing care staff will conduct ongoing oral health assessments
2.) Attending physician will be notified of the residents need for dental treatment and order dental consultation as appropriate.
3.) The attending physician will include, as part of the initial medical assessment, an assessment of the resident's dental needs, Finding will be included in the residents' medical records.

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F 641	Continued From page 3 4.) Our facility's routine dental care includes, but is not limited to: a.) An initial evaluation of the resident's dental needs. b.) Consultation with the resident, staff, and dental consultant A review of the Dental Services Agreement, dated June 6, 2006, provided by the LNHA on 10/20/2022 states: b) "The dentist shall provide Dental Services in full compliance with all the applicable Federal, state, and local laws and regulations, including, without limitation, the applicable rules and regulations of any third-party reimbursement payors concerning Dental Services and that such licenses and certifications are in full force and effect." c.) The dentist shall maintain complete records at the facility of the dental services provided to the residents of the facility in accordance with applicable law ..." NJAC 8:39-33.2 (d)	F 641		
F 755 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(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	F 755		11/4/22

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F 755	Continued From page 4 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, record review, and review of pertinent facility documentation, it was identified that the facility failed to: a.) acquire and administer a medication per Physician's Order (PO) for one of two residents', (Resident #229) reviewed for mood and behavior and b.) accurately reconcile a controlled substance stored in a medication cart. This deficient practice was identified during the controlled substance reconciliation count for one of two medication carts and identified for, (Resident #66 and #69). This deficient practiced was evidenced by the following: 1. On 10/12/22 at 12:25 PM, the surveyor observed Resident #229 in their room finishing up	F 755	Electronic Medication Record is to be check against medication in medication cart to assure that all medication cart to assure that all medications are available. all licensed nurses were educated on facility protocol when medication is not available to check back up supply, reach out to physician notify and call the pharmacy for emergency delivery and document all out outcome. No other resident were affected by this deficient practice. Director of Nursing educated all nurses on policy of reconciling medications. No resident were affected by this deficient practice	

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F 755	Continued From page 5 with his/her lunch. The surveyor asked the resident how they were, and the resident stated, [redacted]." On 10/13/22 at 1:10 PM, the surveyor observed Resident #229 walking in front of the nursing station on the [redacted] unit. The surveyor asked the resident how he/she slept last night, and the resident stated that he/she slept well because the nurse gave him/her the medication that helped them sleep. The surveyor reviewed the medical record for Resident #229. A review of the resident's Admission Record reflected that the resident was [redacted] admitted to the facility and had diagnoses which included but were not limited to EX Order 26 § 4b1 [redacted] A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 10/13/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident was [redacted] A review of the resident's October 2022 Order Summary Report (OSR) reflected a PO dated 10/12/22 for the EX Order 26 § 4b1 [redacted] A review of the resident's October 2022 Medication Administration Record (MAR)	F 755	Director of Nursing Audit all Electronic medical records were checked against medications in medication cart to assure that all medications where available for the patients. Director of Nursing or designee audited all medication carts to ensure all meds were reconciled with 2 nurses according to the facility policy All licensed nurses were educated regarding medication times, how to re-time medication , physician notification and documentation, and calling the pharmacy for stat delivery of medication. Director of Nursing or designee educated all licensed Nurses on destroying narcotics policy and DON or designee will audit to ensure that 2 nurses are reconciling narcotics according to the policy The DON or designee will document findings of their audit, identify patterns and trends and review during the quarterly Quality assurance committee times 2 quarters. The DON or Designee will audit medication carts reconciliation weekly times 4 weeks then monthly times 3 months. DON or designee will report all findings will be reviewed . and all findings will be bought to QA committee meetings every 3 months times 2 quarters	

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revealed a PO for the EX Order 26 § 4b1 [redacted] give [redacted] for [redacted]. The October 2022 MAR reflected that on 10/11/22 Resident #229 was not administered the medication EX Order 26 § 4b1.

A review of the corresponding Nursing Progress Note (NPN) dated 10/11/22 and timed at 23:36 (11:36 PM) indicated that the medication EX Order 26 § 4b1 was not administered to the resident and the facility was, "awaiting delivery from pharmacy."

A further review of the October 2022 MAR reflected that on 10/15/22 Resident #229 was not administered the medication EX Order 26 § 4b1.

A further review of the corresponding NPN dated 10/16/22 and timed at 00:21 (12:21 AM) indicated that the facility was awaiting delivery of the medication, EX Order 26 § 4b1 from the pharmacy.

A review of the resident's Care Plan dated 10/11/22 reflected a focus area that the resident was at risk for [redacted] related to [redacted]. The goal of the resident's Care Plan was the resident would accept care and medications as prescribed. The interventions within the resident's Care Plan included administer medications per physician orders.

On 10/13/22 at 10:36 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated the resident was alert, oriented and able to make his/her needs known. The CNA further stated that when she started her shift at 7:00 AM that day, she observed the resident awake, lying in bed, and throughout the day the

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resident would freely walk around the unit. The CNA told the surveyor that the resident liked to joke around with staff and never mentioned to her that he/she did not get a good night sleep.

On 10/18/22 at 11:14 AM, the surveyor interviewed the resident's Registered Nurse (RN) who stated that the resident was alert and oriented and was able to tell staff his/her needs. The RN told the surveyor that the resident was capable of specifically asking for medications that he/she needed and gave the example that the day before, the resident had asked her for a medication for EX Order 26 § 4b1. The RN further stated that the resident had a routine PO for the EX Order 26 § 4b1 medication EX Order 26 § 4b1 at nighttime. The RN explained that if a medication was not available, she would first check to see if the medication was available in the "back-up" at the facility and then let the resident's physician know if it wasn't. The RN stated that she would call the pharmacy to find out why the medication was not available and get a stat (immediate) delivery of the medication. The RN further explained that she would discuss with the resident's physician, resident, and resident representative an alternative medication or means to help the resident sleep in the meantime. The RN told the surveyor that after she implemented these interventions for the unavailable medication, she would then document what she did for the resident.

On 10/20/22 at 11:57 AM, the surveyor conducted an interview with the Consultant Pharmacist (CP) over the telephone in the presence of the facility's Administrator. The CP stated that if a medication was not available, nursing should first check for availability in the back up medication dispensing

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F 755	Continued From page 8	F 755		

machine at the facility. The CP further stated that the nurse should notify the supervisor working and the resident's physician if necessary.

On 10/20/22 at 12:02 PM, the surveyor interviewed the facility's Administrator who stated that the nurse who was responsible for administering the medication should have followed facility protocol which included notifying the resident's physician and calling the pharmacy provider for a stat delivery. The Administrator further stated that the medication EX Order 26 § 4b1 was not in the back up medication dispensing machine.

A review of the facility's, "Administering Medication Policy and Procedure" edited 5/21/22 indicated that it was the facility's policy to administer medications in a safe and timely manner as prescribed. The "Administering Medication Policy and Procedure" further indicated, "Medications are administered in accordance with prescriber orders, including any required time frame."

2. On 10/14/22 at 10:30 AM to 10:42 AM, the surveyor inspected Medication Cart #1 on the [redacted] unit in the presence of the RN. The surveyor reviewed the bingo card that contained EX Order 26 § 4b1 [redacted] for Resident #66 and identified that EX Ord [redacted] were present. At that time, the surveyor reviewed Resident #66's corresponding Controlled Drug Administration Record in the presence of the RN which indicated EX Order 26 § 4b1 [redacted] should have been present in the bingo card. This documentation reflected that there was an excess of one EX Order 26 § 4b1 for Resident #66.

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The surveyor reviewed the bingo card that contained EX Order 26 § 4b1 for Resident #69 and identified that EX Order 26 § 4b1 were present. At that time, the surveyor reviewed Resident #69's corresponding Controlled Drug Administration Record in the presence of the RN which indicated EX Order 26 § 4b1 should have been present in the bingo card. This documentation reflected that there was one less EX Order 26 § 4b1 for Resident #69.

The RN stated that the medication EX Order 26 § 4b1 was signed on the wrong Controlled Drug Administration Record and that was why there was a discrepancy. The RN further stated that the medication EX Order 26 § 4b1 was not administered to the resident. The RN explained that the foil behind the EX Order 26 § 4b1 bingo card was ripped, making it easy for the medication to fall out, so her and another nurse decided to dispose of the medication. A further review of the Controlled Drug Administration Record revealed that two nurses did not sign as witnesses for the destruction of the controlled medication for the EX Order 26 § 4b1 or th EX Order 26 § 4b1 as required on the Controlled Drug Administration Record. The RN stated that the Controlled Drug Administration Record for Resident #69 containing the EX Order 26 § 4b1 should have had two nurses' signatures because that was the medication that was disposed of.

On 10/14/22 at 11:00 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the nurses should have

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F 755	Continued From page 10	F 755		

notified the supervisor as soon as they signed for the wrong medication and had the medication destroyed properly. The ADON stated that the correct way to dispose of a controlled medication was for two nurses to put the medication in the drug buster and both nurses should have signed the Controlled Drug Administration Record for the destruction of the medication.

On 10/17/22 at 11:14 AM, the surveyor interviewed the CP in the presence of the Administrator who stated that the nurses would count the [redacted] inventory on each medication cart at the beginning and end of each shift for accountability. The CP further stated that the nurses had to make sure the count on the medication bingo card matched the count on the Controlled Drug Administration Record. The CP told the surveyor that the appropriate procedure was for two nurses to witness and sign for the destruction of the [redacted] medication on the Controlled Drug Administration Record.

On 10/18/22 at 1:35 PM, the surveyor interviewed the Administrator who stated that it was the facility's policy for two nurses to sign as witnesses for the destruction of the narcotic.

A review of the facility's, "Controlled Drugs Record/Controlled Drug Index Policy and Procedure" revised 5/1/22 indicated that maintaining an accurate inventory of controlled drugs must occur and the facility was to ensure that all controlled substances were accounted for in a manner that promoted proper security and accountability. The "Controlled Drugs Record/Controlled Drug Index Policy and Procedure" further indicated that any discrepancy in the count must be reported to the supervisor

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F 755	Continued From page 11 immediately for investigation and that all sections of the Controlled Drug Administration Record form must be completed. NJAC 8:39-29.2(d),29.4(c),29.7(c)	F 755		
F 791 SS=E	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;	F 791		11/4/22

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CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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F 791	Continued From page 12 §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide the mandatory annual dental care services. This deficient practice was observed for 1 of 17 facility residents reviewed for dental care services, (Resident #10), as evidenced by the following: On 10/12/2022 at 12:55 PM, the surveyor observed that Resident #10 had dentition issues. The resident's teeth were EX Order 26 § 4b1 [redacted] When the surveyor inquired if his/her mouth was [redacted] or if he had any problems eating? Resident #10 stated, "no he/she did not have pain or eating issues." On 10/18/22 11:39 AM, The surveyor observed the resident in bed and chewing on the corner of the bed blanket. A review of the Admission Record revealed the resident was admitted to the facility on [redacted] with a diagnosis that included [redacted] The resident is a recipient of Medicaid Wellcare MLTSS (Managed Long-Term Services and	F 791	The affected resident was seen by the dentist on 10/31/22 No other resident were affected by this deficient practice DON or designee educated all licensed nurses on facility policy for dental services routine 24 hour emergency dental care. all licensed were educated when a resident is identified with dental issues to obtain order from doctor for a dental consult. All licensed Nurses will evaluate all new patients for the need of dental care and follow up with the dentist and document as needed. All residents will be evaluated yearly and as needed for dental care services. The DON or designee will perform audits monthly times 3 months then quarterly times 2 quarters to ensure all residents	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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F 791	Continued From page 13 Support) insurance. A review of the Resident Evaluation with Covid-19 Screen, dated 07/30/2020 at 21:15, it revealed under section E. Oral /Dental and Hearing/Speech/Vision/Diet with #4 is checked as: EX Order 26 § 4b1 [redacted] A review of the Quarterly Minimum Data Set (MDS), dated 04/14/2022, revealed the resident had Brief Interview for Mental Status (BIMS), score of [redacted], EX Order 26 § 4b1. It further revealed under section L, Oral/Dental status that "none of the above were present." A review of the annual MDS, dated 0 7/28/2022 revealed the resident had BIMS, score of [redacted] EX Order 26 § 4b1. It further revealed under section L, Oral/Dental status that "none of the above were present." A review of the Order Summary Report with the Regional Registered Nurse (RRN) on 10/19/2022 at 11:55, it revealed that there was not an order for a dental consultation. A complete review of the resident's medical record did not reveal documentation that the resident was offered and refused dental care services. A review of the resident's Care Plan (CP), dated 07/30/2020, revealed an initiated revision date of 10/20/2022, to reflect a focus area for "At risk for Dental or [redacted] on admission." This care plan's revision date 10/20/2022, was initiated by the facility, post surveyor's inquiry.	F 791	are seen by the dentist in a timely manner The DON or designee will report findings to the QA committee quarterly meetings times 2 quarters	

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	315468	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

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F 791	Continued From page 14	F 791		

An interview on 10/19/2022 at 11:19 AM, with the RRN stated, "that the dental consult should have been triggered from the Resident Evaluation with Covid-19 Screen, dated 07/30/2020 at 21:15". Upon record review with her during the interview, she was unable to find a physician's order (PO) for a dental consultation, nor was there evidence of a refusal of dental evaluation or services noted within the eMAR or hard chart.

During a second interview 10/19/2022 at 12:06 PM, the Regional Registered Nurse stated, "the resident has never been seen during his/her stay in the facility, but the unit manager reached out to the contracted dentist and faxed over his/her face sheet to start the process."

An interview on 10/20/22 at 11:11 AM, the unit manager stated, "after initial assessment of a newly admitted resident by the nurse, the nurse then calls the physician and gives a report of their findings, to include the medications the resident was on, and then telephone orders would be given according to the needs of the resident. The physician would then follow up either that day or the next day."

During an interview with the Director of Nursing (DON) on 10/20/22 at 01:22 PM, he stated, "The resident would have a PO for a referral for a dentist. If there was an issue they would reach out to the dentist. A Long-Term Care resident is required to be seen by a dentist every six months. Moving forward, the facility will audit all the residents to see if they need to be seen by a dentist for issues or annuals. The nurses would then request a PO for a dental consult, and document it."

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	315468	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

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F 791	Continued From page 15 On 10/20/2022 at 01:34 PM, the above concern was discussed with the Assistant Director of Nursing (ADON) and Licensed Nursing Home Administrator (LNHA). A review of the facility's Routine Dental Care policy, revised April 2022, provided by the LNHA on 1/19/2022, indicated: 1.) Nursing care staff will conduct ongoing oral health assessments 2.) Attending physician will be notified of the resident's need for dental treatment and order dental consultation as appropriate. 3.) The attending physician will include, as part of the initial medical assessment, an assessment of the resident's dental needs. Finding will be included in the residents' medical record. 4.) Our facility's routine dental care includes, but is not limited to: a.) An initial evaluation of the resident's dental needs. b.) Consultation with the resident, staff, and dental consultant c.) Daily dental and oral hygiene plan of care d.) Inservice education; and e.) Preventative care and treatment A review of the Dental Services Agreement, dated June 6, 2006, provided by the LNHA on 10/20/2022 states: b) "The dentist shall provide Dental Services in full compliance with all the applicable Federal, state, and local laws and regulations, including, without limitation, the applicable rules and regulations of any third-party reimbursement payors concerning Dental Services and that such licenses and certifications are in full force and	F 791		

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	315468	A. BUILDING _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

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F 791	Continued From page 16 effect." c.) The dentist shall maintain complete records at the facility of the dental services provided to the residents of the facility in accordance with applicable law ..." NJAC 8:39-15.1(a)	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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S 000	Initial Comments 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: Based on interviews and a review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 11 of 14-day shifts as mandated by the state of New Jersey. This deficient practice was identified and the findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	The facility leadership continues to meet on going and continue to identify staffing challenges and areas to improve Certified Nurses Aide assistant for staffing needs. residents have the potential to be affected. The center has implemented significant above market rate for nurses and certified nursing assistant. incentives include tuition reimbursement, sign-on Bonus program, Employee referral program and additional training if not certified. The center continues to conduct on going job fairs with immediate interviews, as well as walk in applicants and has the ability to expedite contingency offers at the time of	11/4/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/04/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	10/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 9/25/22 through 10/01/22 and 10/02/22 through 10/08/22, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -09/25/22 had 7 CNAs for 73 residents on the day shift, required 9 CNAs. -09/26/22 had 7 CNAs for 73 residents on the day shift, required 9 CNAs. -09/27/22 had 6 CNAs for 73 residents on the day shift, required 9 CNAs. -09/28/22 had 7 CNAs for 73 residents on the day shift, required 9 CNAs. -09/29/22 had 8 CNAs for 73 residents on the day shift, required 9 CNAs.	S 560	interview. The center continues to supplement with agency until staff is hired and The center is contracted with multiple agencies that we are currently and have been using. Center continues to post ads throughout various websites, and also flyers posted for all the job openings as recruitment effort The director of Nursing or designee will monitor the certified nursing aide staffing ratios daily and document a weekly review of the daily staffing needs times 4 weeks then twice monthly for two months to monitor. The audits will be presented to the administrator. The DON/Designee will present the results of the audits to the Quality Assurance Performance improvement committee for review on a monthly basis for three months. The committee will review and revise the plan if needed	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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S 560	Continued From page 2 -09/30/22 had 5 CNAs for 72 residents on the day shift, required 9 CNAs. -10/01/22 had 6 CNAs for 73 residents on the day shift, required 9 CNAs. -10/02/22 had 5 CNAs for 72 residents on the day shift, required 9 CNAs. -10/03/22 had 8 CNAs for 71 residents on the day shift, required 9 CNAs. -10/04/22 had 7 CNAs for 67 residents on the day shift, required 8 CNAs. -10/08/22 had 6 CNAS for 60 residents on the day shift, required 7 CNAs. On 10/21/22 at 10:05 AM, the surveyor interviewed the Staffing Coordinator who acknowledged the new minimum staffing requirements for nursing homes. She stated, "some days we are meeting the new mandate, most of the days, but sometimes the 11-7 shift is not meeting the new staffing mandate." There was no additional information provided.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315468	A. Building B. Wing	12/14/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 10/31/2022	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 11/04/2022	ID Prefix F0791 Reg. # 483.55(b)(1)-(5) LSC	Correction Completed 11/04/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
10/24/2022

☐ 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 (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
PSIFQU		12/14/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/04/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
10/24/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING **01** B. WING _____	**10/24/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT PARSIPPANY	**100 MAZDABROOK ROAD** **PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/24/22, 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 The facility is a one-story building with no basement, that was built in 2001, It was composed of Type V protected construction. The facility was divided into 6-smoke zones. The generator does approximately 50 % of the building.	K 000		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/07/2022

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.