STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING _____ B. WING _____	C 08/13/2024

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 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 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 Complaint #s: NJ175641, NJ175631, NJ175068, NJ172994, NJ172310, NJ171672, NJ168554, NJ168223, NJ165579 Survey Dates: 08/06/2024 through 8/13/2024 Census: 68 Sample Size: 17 + 3 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. 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, and record review it was determined that the facility failed to accurately code the Minimum Data Set ((MDS), an assessment tool used to facilitate the management of care), in accordance with federal	F 641	Resident 61 was discharged to home on [redacted NJ Ex Order 26.4(b)(1)]. Resident 61 MDS was Modified on [redacted NJ Exec Order 26.4] to reflect [redacted NJ Ex] actual discharge status. Resident 61 had had [redacted NJ Ex] [redacted] related to this practice.	8/16/24

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

Electronically Signed | 09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 1 guidelines for 1 of 20 residents, (Resident #61) reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 8/9/24 at 8:49 AM, the surveyor reviewed the closed medical chart for Resident #61. The Discharge Assessment MDS revealed that the resident was discharged to an [redacted] hospital. The surveyor reviewed the nursing/clinical progress note dated [redacted], documented that Resident #61 "Resident discharged [redacted]." Review of Resident #61's Face Sheet (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility with diagnosis that included but not limited to [redacted], [redacted], and [redacted]. Review of Resident #61's Discharge MDS dated [redacted] under Section A revealed that section Discharge Status" documented, "[redacted] General Hospital." On 8/9/24 at 9:15 AM, the surveyor interviewed the [redacted]) who was responsible of completing the MDS's. The [redacted] stated, "The resident was discharged home from the facility. I made a mistake and miscoded that resident." According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023) on Chapter 2-page 39 ... "According to the latest version of the Center for	F 641	All resident have the potential to be affected. Clinical reimbursement coordinator (CRC) immediately modified the MDS for resident 61 on [redacted]. 8/9/2024 The VP of Clinical reimbursement provided in service education to the [redacted] on accuracy of Coding the discharge MDS. The VP of Clinical reimbursement conducted an audit of all residents discharged status on the MDS for dates including 8/9/2023 to 8/9/2024 to ensure accuracy of the MDS coding under section A2105. The Clinical reimbursement coordinator will conduct monthly audits of all discharged residents MDS to ensure accuracy of coding under section A for discharge status. This will be on an on Going basis. The result of the audit will be provided monthlyx 3 months, then quarterly x 3 quarters to the facility administrator and QAPI Commitee for review and comment. THe QAPI commitee Meets on a monthly basis. THe Qapi Committee will review and determine the need for further audits	

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F 641	Continued From page 2	F 641		

Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2023). This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. Code 01, Home/Community: if the resident was discharged to a private home, apartment, board, and care, assisted living facility, group home, transitional living, or adult foster care. A community residential setting is defined as any house, condominium, or apartment in the community, whether owned by the resident or another person; retirement communities; or independent housing for the elderly. Code 04, Short-Term General Hospital (acute hospital/IPPS): if the resident was discharged to a hospital that is contracted with Medicare to provide acute, inpatient care and accepts a predetermined rate as payment in full. Code 99, Not Listed"

On 8/9/24 at 11:45 AM, the U.S. FOIA (b) (6) provided the surveyor with a facility policy titled, Certifying Accuracy of the Resident Assessment with a revision date of 11/2019. Review of the policy interpretation and implementation section of the policy states, 2. "Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment."

On 8/9/24 at 12:58 PM, the survey team met with the Regional Clinical Nurse (RCN#1), U.S. FOIA (b) (and U.S. FOIA (b) (6)) regarding the above concern. The RCN#1 stated all MDS assessments must be filled out correctly. The

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F 641	Continued From page 3 RCN also acknowledged there was an error regarding Resident #61 Discharge MDS. On 8/12/24 at 10:03 AM, the surveyor team met with RCN#2, [redacted] and [redacted] There were no further information was provided.	F 641		
F 655 SS=D	NJAC 8:39-11.1, 11.2(e)(1) Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.	F 655		9/2/24

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F 655	Continued From page 4 (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Complaint #: NJ165579 Based on observation, interview, and record review, it was determined that the facility failed to initiate a baseline care plan (CP) for a resident who was admitted with a NJ Ex Order 26.4(b)(1) [redacted]). This deficient practice was identified for 1 out of 3 residents reviewed, Resident #62, and was evidenced by the following: On 08/08/24 at 01:47 PM, the surveyor reviewed Resident #62's medical records, which revealed the resident was admitted to the facility on NJ Ex Order 26.4(b) with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order [redacted], and NJ Ex Order 26.4(b)(1) [redacted]. Resident #62 was discharged to the	F 655	Resident 62 was discharge NJ Ex Order 26.4(on NJ Ex Order 26.4(b [redacted]. Resident 62 had NJ Ex Order 26.4(b)(1) [redacted] related to this practice. All resident have the potential to be affected. The Director of Nursing and Assistant Director of Nursing Immediately conducted an audit of all residents in the facility, who were admitted with a pressure ulcer to ensure the Careplan addressed the issue including a focus, a goal and appropriate interventions. THe director of Nursing Provided inservice Re-education to all nurses on the policy to create a baseline careplan within 48 hours of admission. The baseline Care plan is to include the minimum healthcare information to properly care for a resident including but not limited to initial goals based on admission orders, physician's orders,	

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F 655	Continued From page 5 hospital on [redacted]. A Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated [redacted] under section [redacted] revealed that the resident had NJ Ex Order 26.4(b)(1) [redacted], with [redacted] and NJ Exec Order 26.4b1 [redacted]. Further review of the MDS under section M revealed that Resident #62 had NJ Exec Order 26.4b1 [redacted] that was present on admission. A review of the Admission Nursing Assessment dated [redacted] under section [redacted] revealed Resident #62 had a NJ Ex Order 26.4(b)(1) [redacted] A review of Resident #62's interdisciplinary person-centered comprehensive CP did not identify that the resident had a [redacted] present on admission. On 08/13/24 at 09:50 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who acknowledged that the CP did not address the NJ Ex Order 26.4b1 [redacted] on admission. A review of the facility policy titled "Care Plans, Comprehensive Person-Centered" with a revised date of December 2016 with an edited date of 04/25/22 revealed under section 2. The care plan interventions are derived from a thorough analysis of the information gathered in the comprehensive assessment. Under section 9. Revealed that areas of concern identified during the resident's assessment will be evaluated before interventions are added to the care plan.	F 655	dietary orders, Therapy orders, social services, PASSR etc... The Director of Nursing will audit all new admission to ensure baseline care plan has been initiated within 48 hours of admission and includes the minimum healthcare information as required to properly care for the resident. The audits will be conducted daily x 7 days, then weekly x 4 weeks, then monthly x 3 months. The results of the audits will be provided monthly x 3 months then quarterly x 3 quarters to the facility administrator and QAPI committee for review and comment. The QAPI committee meets on a monthly basis. The QAPI Committee will review and determine the need for further audits.	

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F 655	Continued From page 6 NJAC 8:39-11.2 (d)	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ168223 NJ168554 Based on observation, interview, and record review, it was determined that the facility failed to: a.) clarify a physician's order (PO) for a medication route on a resident who was [redacted]; b.) document the [redacted] care performed; and c.) document an assessment on a resident who was transferred to the hospital for a scheduled [redacted]. This deficient practice was identified for 3 of 12 Residents (Resident #22, #64, and #262) reviewed. 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	F 658	Resident 22 physician orders for: [redacted], 2 tablets every 6 hours prn [redacted], [redacted] hours prn for no [redacted] in 3 days, [redacted] tablet (1 Tab) daily, [redacted] Tablet (1 Tab Daily [redacted] capsule (1capsule) every 8 hours Prn for [redacted] were all clarified to be administered via [redacted] Resident 22 had [redacted] effects related to this practice. Resident #64 was transferred to [redacted] on [redacted] for scheduled [redacted]. Resident#64 had [redacted] related to this practice. Resident #262 had a plan of care dated [redacted] that included [redacted] care. Interventions included but were not limited to change [redacted] as needed, [redacted] per physicians orders, record [redacted] and report abnormalities, report [redacted] or [redacted] at [redacted]. Resident #262 had [redacted] on	9/2/24

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F 658	Continued From page 7 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 deficient practice was evidenced by the following: 1. On 8/6/24 at 10:10 AM, the surveyor observed Resident #22 in their room in bed with eyes closed. The surveyor interviewed Resident #22's family who stated the resident does not take any medications NJ Ex Order 26.4(b)(1). On 8/6/24 at 11:16 AM, the surveyor reviewed Resident #22's paper and electronic medical chart which revealed the following: A review of the Resident #22's Admission Record (AR) (an admission summary) documented that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1).	F 658	NJ Ex Order 26.4b1. Resident #262 had NJ Exec Order 26.4b1 related to this practice. All residents have the potential to be affected. The Director of Nursing and Assistant Director of Nursing immediately conducted an audit of all residents in the facility, who are NPO to verify Medication orders are accurate as to the route of administration. The Director of Nursing Conducted in-service education with all nurses on the importance of verifying the route of administration for all residents, but specially those who have orders for NPO (nothing By mouth). The Director of Nursing and Assistant Director of Nursing Conducted an Audit of all residents who were transferred out for planned surgical procedures, in the last 30 days, to ensure documentation of an assessment was present in the medical record. There were no residents transferred for planned surgical procedures in the last 30 days. The Director of Nursing conducted in service education to all nurses on the importance and procedure for documentation (written Progress note) for all residents who are transferred from the facility, pending planned procedures. Documentation will include , but not limited to: full Body assessment, Vital signs (HR, BP, TEMP, Respirations, O2 Saturation), Disposition, as well as	

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F 658	Continued From page 8 A review of Resident #22's Minimum Data Set (MDS), an assessment tool used for the management of care, dated [NJ Ex Order 2], documented the resident had a Brief Interview for Mental Status (BIMS) and score of [NJ] out of 15, indicating that Resident #22 had NJ Ex Order 26.4(b)(1) [redacted] A review of the [NJ Ex Order 26.4(b)(1)] Order Summary Report (OSR) included a PO dated [NJ Ex Order 26.4] for, '[NJ Ex Order 26.4(b)]', [NJ Ex Order 26.4(b)(1)], for NJ Ex Order 26.4(b)(1) [redacted] ". Further review of the [NJ Ex Order 26.4(b)(1)] OSR revealed the following PO: 1.'NJ Ex Order 26.4(b)(1) , give 2 tablets by mouth every 6 hours as needed for [NJ Ex Order 26.4(b)] [redacted]", dated [NJ Ex Order 26.4]; 2. '[NJ Ex Order 26.4(b)(1)] [redacted]. Give [NJ Ex Order] by mouth every 24 hours as needed for NJ Ex Order 26.4(b)(1) for 3 days", dated [NJ Ex Order 26.4]; 3. 'NJ Ex Order 26.4(b)(1) [redacted], give 1 tablet by mouth one time a day for [NJ Ex Order 26.4] dated [NJ Ex Order 26.4]. 4. 'NJ Ex Order 26.4(b)(1) [redacted], give 1 tablet by mouth one time a day for [NJ Ex Order 26.4(b)(1)] dated [NJ Ex Order 26.4]; 5. '[NJ Ex Order 26.4(b)(1)] [redacted], give 1 capsule by mouth every 8 hours as needed for [NJ Ex Order 26.4(b)(1)] dated [NJ Ex Order 26.4]. On 8/7/24 at 10:31 AM, the surveyor interviewed Registered Nurse (RN#3), who was the regular 7-3 shift nurse for Resident #22. RN#3 acknowledged to the surveyor that the above five (5) medications route were incorrect and should have indicated to be administered via the NJ Ex Order 26.4(b)(1). All the other medications of Resident #22 were administered via [NJ Ex Order 26.4(b)(1)] [redacted]	F 658	notification to resident representative for the date and time resident is being transferred to the hospital for the planned (Surgical Procedure). The Director of Nursing and assistant Director of Nursing Conducted an Audit of all residents residing in the facility with Colostomy (and/or Ostomy appliances) to ensure physician's orders for colostomy care were Present. The Director of Nursing provided in service re-education to all nurses on the policy for "Colostomy/Ostomy Care" and to ensure Physician orderes are present for the care and monitoring of residents with Ostomy appliances. The Director of Nursing or Designee will conduct audits of all new admission with NPO orders related to peg-tube placement to ensure the correct route has been entered for all medications. Audits will be conducted daily x 7 days , then weekly x 4 weeks then monthly x 3 months. THe Director of Nursing or Designee will conduct weekly audits of documentation for 100 percent of residents with transfers for planned surgical procedures. The audits will be conducted weekly x 4 weeks, then monthly x 3 months , then quarterly x 3 quarterly x 3 quarters. The Director of Nursing or designee will conduct weekly audits of all residents who have Ostomy or appliance to ensure a physician order is present for the assesment and care of the ostomy. Audits will be conducted weekly x 4 weeks, Then monthly x 3 months, then quarterly x 3	

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F 658	Continued From page 9 On 8/9/24 at 11:45 AM, the U.S. FOIA (b) (6) provided the surveyor with a facility policy titled, "Physician Services" with a revision dated of 2/2021. Under the policy interpretation and implementation revealed under "6. Physician orders and progress notes are maintained in accordance with current OBRA regulations and facility policy." On 8/9/24 at 12:58 PM, the survey team met with the U.S. FOIA (b) (6)), and Regional Clinical Nurse (RCN#2). The RCN stated acknowledged that the medication route was incorrect for Resident #22 who was NJ Exec Ord No further information was provided. 2. On 8/06/24 at 12:17 PM, the surveyor reviewed the closed medical records of Resident #64 which revealed the following: A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) A review of the Admission MDS, an assessment tool used to facilitate the management of care,	F 658	quarters. The results of all the audits will be provide monthly x 3 months, then quarterly x 3 quarters to the facility administrator and QAPI committee for review and comment. THe QAPI Committee meets on a monthly basis. The QAPI Committee will review and determine the need for further Audits	

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F 658	Continued From page 10	F 658		

dated [NJ Ex Order 26.4], reflected that Resident #64 had a BIMS score of [redacted] out of 15, indicating a [NJ Ex Order 26.4] [redacted]

A review of the facility Progress Notes (PN) revealed a Physician/Practitioner Progress Note dated [NJ Ex Order 26.4] at 13:40 (1:40 PM) documented the following: "Patient is scheduled for [NJ Ex Order 26.4] [redacted] on Friday, [NJ Ex Order 26.4(b)(1)] [redacted] Patient needs to arrive at hospital [name redacted] by 11:00 AM.

A further review of the resident's medical records revealed no written PN or nursing assessment on the morning of [NJ Ex Order 26.4] that would indicate the resident was admitted to the hospital for [redacted] There was no full body assessment, vital signs (measurements of the body's basic functions including temperature, heart rate, respiratory rate, blood pressure and oxygen saturation (the amount of oxygen circulating in your blood), documentation regarding the resident's disposition and a PN which would indicate if the resident's family were notified when the resident was transferred to the hospital for a NJ Ex Order 26.4(b)(1)

The PN revealed a PO administration note from the facility nurse dated [NJ Ex Order 26.4(b)] at 19:47 (7:47 PM) which revealed the following: "out for [NJ Ex Ord] [redacted]."

On 8/9/24 at 11:00 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1) on the unit who stated that when a resident is being sent out to the hospital for a NJ Ex Order 26.4b1, a nursing staff will review the resident's medical records and if they identify anything that could

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	315468	A. BUILDING _____ B. WING _____	C 08/13/2024

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 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 658	Continued From page 11	F 658		

arise to a concern, the nurse will reach out to the physician. She also stated that all communication with the physician must be documented in the medical records. LPN #1 added that if a resident will be transferred out to the hospital, the nurses are also required to document in the resident's medical records.

On 8/09/24 at 1:00 PM, the surveyor presented the above concerns to the U.S. FOIA (b) (U.S. FOIA (b and RCN#2. The U.S. FOIA acknowledged that the nurse should have written a PN documenting but not limited to full body assessment and vital signs prior to the resident being transferred to the hospital for the NJ Ex Order 26.4(b)(1).

There was no additional information provided.

3. On 8/05/24 at 12:17 PM, the surveyor reviewed the closed medical records of Resident #262 which revealed the following:

A review of the AR reflected that the resident was admitted to the facility with diagnoses that included but not limited to encounter for NJ Ex Order 26.4(b [redacted]), NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1 [redacted].

A review of the Admission MDS, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b), reflected that Resident #262 had a BIMS score of NJ Ex out of 15, indicating that the resident was NJ Ex Order 26.4(b)(1).

A review of the OSR revealed the following PO:

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A PO dated [redacted] for [redacted] every shift.
A PO dated [redacted], for [redacted] every shift.

A review of the [redacted], electronic Treatment Administration Record (eTAR) and the [redacted] electronic Medication Administration Record (eMAR) did not indicate a PO for [redacted] every shift and no PO for [redacted] every shift. There were no documentation in the hybrid medical record which reflected that both [redacted] or [redacted] were documented every shift.

A review of Resident #262's Comprehensive Care Plan dated [redacted], for [redacted] which revealed the following interventions/tasks:
-Change [redacted] appliances as needed, dated [redacted].
-[redacted] per physician's orders dated [redacted].
-Record [redacted] movements and report abnormalities dated [redacted]

On 8/9/24 at 8:30 AM, the surveyor interviewed LPN #1 regarding the process of documenting the [redacted] care in the medical record. LPN #1 stated that a physician would write a PO for [redacted] care and the nurses will document this in the eTAR. LPN #1 further stated that only the nurses can document [redacted] care. LPN #1 added that changing a [redacted], documenting [redacted], and assessing the [redacted] must be documented every shift in the eTAR. LPN #1 stated that assessing the

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NJ Ex Order 2 site around the NJ Ex Order 26.4(b)(1) is a separate assessment from the NJ Exec Order 26.4b1 assessments since nurses must assess the NJ Ex Order 26.4(b)(1) every shift.

On 8/9/24 at 8:45 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who stated to the surveyor that NJ Ex Order 26.4b1 must be documented in the resident's medical record and only the nurses could document. The U.S. FO added that it must be documented in the eTAR.

On 8/09/24 at 1:00 PM, the surveyor presented the above concerns to the U.S. FOIA (b) (U.S. FOIA (b and RCN#2. Both the U.S. FOIA and RCN#2 acknowledged that nurses should have documented the NJ Ex Order 26.4(b)(1) care in the eTAR. There was no additional information provided.

A review of the facility's policy for "Colostomy/Ileostomy Care" that was dated 10/2010 and was provided by the U.S. FOIA included the following:
Under documentation: " The following information should be recorded in the resident's medical record:
1. The date and time the colostomy/ileostomy care was provided.
2. The name and title of the individual (s) who provided the colostomy/ileostomy care."

A review of the facility's policy for "Charting and Documentation" that was undated and was provided by the U.S. FOIA included the following:
"4. The following information is to be documented in the resident medical record:
a. Objective observations.
b. Medications administered.

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F 658	Continued From page 14 c. Treatments or services performed. d. Changes in the resident's condition. e. Events, incidents, or accidents involving the residents; and f. Progress toward or changes in the care plan goals and objectives." NJAC 8:39-19.4 (a) (1) NJAC 8:39-11.2(b)	F 658		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a resident on NJ Ex Order 26.4(b)(1)) was consistently assessed, documented, and monitored after NJ Ex Order 26.4(b)(1) treatments. This deficient practice was identified for 1 of 1 resident's (Resident #10) reviewed for NJ Ex Order 26.4 and was evidenced by the following: On 08/06/24 at 10:56 AM, the surveyor was touring the NJ Ex Order 26.4b1, and Resident #10 was not in their room and was informed that the resident was out at NJ Ex Order 26.4(b)(1) On 08/07/24 at 11:15 AM, the surveyor observed	F 698	Resident #10 Continues with NJ Ex Order 26.4(b)(1) treatments on Tuesday, Thursday and Saturday. Resident #10 NJ Ex Order 26.4(b)(1) Communication Binder was immediately updated to include a form for NJ Ex Order 26.4(b)(1) assessment That includes vital signs, assessment of the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(significant change, etc. as well as the receiving nurse signature and date. Resident # 10 has NJ Exec Order 26.4b1 related to this practice. All Residents have the potential to be affected. The Director of Nursing and Assistant	9/2/24

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F 698	Continued From page 15 Resident #10 in their room, but the resident declined to be interviewed. A review of the Admission Record face sheet revealed that Resident #10 had diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted], and NJ Ex Order 26.4(b)(1) [redacted] A review of the Order Summary Report under special instructions revealed the resident goes to NJ Exec Order 26 [redacted] every Tuesday, Thursday, and Saturday. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated NJ Ex Order 26.4(b)(1) [redacted] revealed a Brief Interview from Mental Status (BIMS) of NJ Ex [redacted] out of 15, which indicated the resident's cognition NJ Ex Or [redacted] The MDS also indicated the resident received NJ Ex Order 26.4(b)(1) [redacted] A review of the resident-centered care plan included but was not limited to a focus area that the resident had NJ Ex Order 26.4(b)(1) [redacted] and received NJ Ex Order 26.4(b)(1) [redacted] on Tuesday, Thursday, and Saturday with interventions that included, confer with a physician and or NJ Ex Order 26.4 [redacted] treatment center regarding changes in medication administration time/dosage NJ Ex Order 26.4(b)(1) [redacted] as needed and coordinate NJ Ex Order 26.4(b)(1) [redacted] with the NJ Ex Order 26.4 [redacted] A review of the form titled, "NJ Ex Order 26.4 [redacted] Center Communication Record" for Resident #10 revealed the first section to be filled out by the facility nurse which included the resident's name,	F 698	Director of Nursing conducted an audit of Hemodialysis Communication Binders for all residents who are on Hemodialysis to ensure the form was present for pre and post dialysis assessment, including the nurses signature and date. Resident #10 was assessed by the Director of Nursing on NJ Ex Order 26.4(b) [redacted] upon return from NJ Ex Order 26.4(b)(1) [redacted] with NJ Ex [redacted]. The Director of Nursing conducted in service re-education with all nurses on the policy and procedure for Hemodialysis Pre and post care including but not limited to documenting communication (pre-Dialysis) as well as post Dialysis assesment. in the Hemodialysis Communication binder. The Director of Nursing or Designee will conduct an audit of the Hemodialysis Communication Binder to ensure pre and post dialysis assesment is being completed, for all resident on Hemodialysis. Audits Will be conducted weekly weekly x 4 weeks, then monthly x 3 months then quarterly x 3 quarters. THe result of all audits will be provided monthly x 3 months, Then quarterly x 3 quarters to the facility administrator and QAPI committe for review and comment. The QAPI committee meets on a monthly basis. THe QAPI Committee will review nd determine the need for further audits	

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treatment date if the resident is receiving [redacted] medication, had any [redacted] or had [redacted] in the last 48 hours. An area was to be filled out for the resident's vital signs, including temperature, pulse, respirations, blood pressure, [redacted], and nurse signature-the following section was to be filled out by the [redacted] center nurse communication back to the center. The areas included the [redacted] start and end time, the pre and post-[redacted] laboratory results, [redacted], treatment problems, medication administered, [redacted] movements, and the signature of the [redacted] nurse.

The last section, "to be completed by skilled nursing facility nurse post-treatment," asked for information including blood pressure, temperature, pulse, [redacted] at the [redacted], [redacted], receiving nurse signature, and date.

A review of the [redacted] Communication binder, which started in [redacted] and documented the following:

[redacted] included eight forms, and 6 out of 8 had incomplete post-treatment filled out. Further review revealed five forms dated [redacted] through [redacted] did not include the last section for the [redacted] treatment documentation.

[redacted] included 13 forms in which [redacted] out of 13 forms had incomplete [redacted] treatment filled out.

[redacted] included 13 forms in which [redacted] out of 13 forms had incomplete [redacted] treatment filled out.

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F 698	Continued From page 17 NJ Ex Order 26.4(b)(1) included three forms in which NJ of the 3 forms had incomplete NJ Ex Order 26.4(b)(1) treatment filled out. On 08/07/24 at 12:30 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated that the communication sheets in the book needed to be consistently filled out and that the nurses should fill them out. On 08/07/24 at 01:00 PM, the surveyor interviewed and reviewed the Communication binder with the U.S. FOIA (b) (6)), who stated that the nursing staff should be documenting on the sheets. On 08/13/24 at 11:03 AM, the surveyor interviewed the U.S. FOIA (b who stated that the NJ Ex Order 26.4(b)(1) assessment was not completed on the communication sheet and acknowledged that it should have been filled out. The U.S. FOIA further stated that the forms for NJ Ex Order 26.4(b) through NJ Ex Order 26.4(b) were filled out but the nurses used the old forms which did not have the NJ Ex Order 26.4(b)(1) treatment section area for documentation. The U.S. FOIA added that it was the reason why the facility changed the forms. A review of the facility provided policy titled, "Hemodialysis Pre and Post Care policy dated 7/00 with a revision date of 3/2010, included but was not limited to; document all communications in the hemodialysis communication progress note or the dialysis center communication book ...assess resident for vital signs ...bleeding ...significant change ...Post dialysis care ...the shunt should be assessed upon return ..., and bandages should remain in place.	F 698		

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F 698	Continued From page 18 NJAC 8:39-27.1(a)	F 698		
F 812 SS=F	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, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 8/7/24 at 09:43 AM, the surveyor entered the kitchen for the follow up tour with the [redacted]	F 812	Chef #1 was immediately provided in-service re-education in the means of hand Hygiene Education was provided from the following: Clinical Safety: Hand Hygiene for Healthcare workers (CDC.gov), Hand Hygiene Competence NJ DOH ICAR. No residents had untoward effects related to this practice. All residents have the potential to be affected.	9/2/24

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F 812	Continued From page 19 On 8/7/24 at 10:38 AM, the surveyor observed Chef (Chef #1) perform hand hygiene. Chef #1 scrubbed their hands with soap for 12 seconds and then rinsed their hands under running water. At 10:44 AM, the surveyor observed Chef #1 again perform hand hygiene. The surveyor observed Chef #1 scrubbed their hands with soap for 8 seconds and rinsed under running water. The surveyor interviewed Chef #1, who stated, "I thought I scrubbed my hands for 20 seconds. I will wash my hands again." On 8/9/24 at 11:45 AM, the U.S. FOIA (b) (6) provided the surveyor with a facility policy titled Handwashing/Hand Hygiene, with a revised date of 10/2023. Under the procedure section and sub section "washing hands" it revealed, 2. "Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers." On 8/9/24 at 12:58 PM, the survey team met with the U.S. FOIA (b) (6)), and Regional Clinical Nurse (RCN#2). The surveyor reviewed the kitchen concerns. No further information was provided. NJAC 8:39-17.2(g)	F 812	The regional nurse and the infection Preventionist immediately provided in-service re-education to chef #1, including but not limited to review to review of the policy and procedure for hand Hygiene , clinical safety: Hand hygiene for healthcare workers (CDC.Gov), as well as hand hygiene Competency. The infection Preventionist and the regional food service director provided in-service re-education for 100 % of the dietary staff on hand Hygiene, Including but not limited to hand Hygiene competency. The food service director or designee will conduct random audits for hand hygiene of 50 % of the dietary staff weekly x 4 weeks, then monthly x 3 months, then quarterly x 3 quarters. The results of all audits will be provided monthly x 3 months, then quarterly x 3 quarters to the facility administrator and QAPI committee for review and comment. THe QAPI Committee meets on a monthly basis. THe QAPI committee will review the need for further audits.	

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 #'s: NJ175641, NJ175631, NJ172310, NJ172994, NJ168554, NJ165579 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios 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.	S 560	The Facility Leadership team has met on going basis and continue to identy staffing challenges and areas of improvement for licensed and certified staffing needs. All resident have the potential to be affected. The facility has implemented a significant above market rate for nurses and certified nursing assistants. The facility has implemented an incentive program for new hires, and referral bonuses for employees referring staff where appropriate. the facility continues to conduct on going	9/2/24

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

Electronically Signed | 09/05/24

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S 560	Continued From page 1 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 resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.	S 560	job fairs, internally and externally with immediate interviews and contingency offers. the facility implemented an expedited on boarding process for new hires. the facility has partnered with Intely care staffing agency and will use agency staff as needed to meet staffing needs. The DON and/or designee meets with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. The DON and or Designee will monitor call outs and staffing ratios weekly until the requirement is met. The nresults of the audits will be forwarded to the facility administrator and QAA committee for further review and recommendations as needed	

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

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S 560	Continued From page 2 (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... 1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period of complaint staffing beginning 7/02/2023 and ending 7/08/2023 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 2 of 7-day shifts, as follows: -07/07/23 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -07/08/23 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. 2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	C 08/13/2024

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 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 560	Continued From page 3 Program Nurse Staffing Report" for the one-week period of complaint staffing beginning 10/1/2023 and ending 10/7/2023 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 2 of 7-day shifts, and deficient in CNAs to total staff on 1 of 7 evening shifts as follows: -10/06/23 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -10/06/23 had 3 CNAs to 8 total staff on the evening shift, required at least 4 CNAs. -10/07/23 had 8 CNAs for 74 residents on the day shift, required at least 9 CNAs. 3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period of complaint staffing beginning 2/04/2024 and ending 02/10/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 7 of 7 day shifts as follows: -02/04/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/05/24 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/06/24 had 9 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/07/24 had 8 CNAs for 77 residents on the day shift, required at least 10 CNAs. -02/08/24 had 7 CNAs for 79 residents on the day shift, required at least 10 CNAs. -02/09/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. -02/10/24 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	C 08/13/2024

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 4 4. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period of complaint staffing beginning 03/10/2024 and ending 03/16/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 6 of 7 day shifts as follows: -03/10/24 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -03/11/24 had 8 CNAs for 73 residents on the day shift, required at least 9 CNAs. -03/12/24 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -03/13/24 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. -03/15/24 had 8 CNAs for 71 residents on the day shift, required at least 9 CNAs. -03/16/24 had 7 CNAs for 71 residents on the day shift, required at least 9 CNAs. 5. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period of complaint staffing beginning 06/30/2024 and ending 07/13/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 9 of 14 day shifts as follows: -07/03/24 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -07/05/24 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -07/06/24 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -07/07/24 had 7 CNAs for 63 residents on the day	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	C 08/13/2024

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

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S 560	Continued From page 5 shift, required at least 8 CNAs. -07/08/24 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -07/09/24 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -07/10/24 had 7 CNAs for 62 residents on the day shift, required at least 8 CNAs. -07/11/24 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -07/13/24 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs. 6. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to survey beginning 07/21/2024 and ending 08/03/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 2 of 14 day shifts as follows: -07/26/24 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. -08/03/24 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs. On 8/13/24 at 10:38 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Regional Clinical Nurse regarding the above concerns. The LNHA stated that he was aware of the mandated CNA ratios. The LNHA stated the facility was working to improve staffing including retaining hired staff and giving incentives.There was no additional information provided by the facility.	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation	S1405		8/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	C 08/13/2024

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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S1405	Continued From page 6 a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that all newly hired employees had completed the required NJ Ex Order 26.4(b)(1) [redacted] by the physician or advanced practice nurse within two weeks prior to the first day of employment or upon employment. This deficient practice was identified for 8 of 9 new hired employees whose personnel record were reviewed, as was evidenced by the following: On 8/8/24 at 09:45 AM, the surveyor reviewed	S1405	Employee #1, date of hire (DOH) [redacted] had a physical NJ Ex Order 26.4(b)(1) [redacted] on [redacted]. Employee #2 DOH [redacted] had a [redacted] on [redacted]. Employee #3, DOH [redacted] had a NJ Ex Order 26.4(b)(1) on [redacted]. Employee # 4, DOH [redacted] had a NJ Ex Order 26.4(b)(1) on [redacted]. Employee # 5, DOH [redacted] had a NJ Ex Order 26.4(b)(1) on [redacted].	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	C 08/13/2024

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S1405	Continued From page 7 the health records for 9 employees hired since NJ Exec Or that showed the following information: 1.) Employee #1 was from Admissions Department with a date of hire (DOH) on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26.4. 2.) Employee #2 was a Dietary Cook with a DOH on NJ Ex Order 26. The NJ Ex was performed by a physician on NJ Ex Order 26. 3.) Employee #3 was a Registered Nurse (RN) with a DOH on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26.4. 4.) Employee #4 was a Licensed Practical Nurse with a DOH on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26.4. 5.) Employee #5 was a RN with a DOH on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26.4(b). 6.) Employee #6 was a Certified Nursing Assistant with a DOH on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26. 7.) Employee #7 was a Physical Therapist with a DOH on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26.4. 8.) Employee #8 was a Social Worker with a DOH on NJ Ex Order 26.4. The NJ Ex was performed by a physician on NJ Ex Order 26.4. On 8/8/24 at 12:55 PM, the survey team met with the facility's Assistant Director of Nursing (ADON) who was responsible of the new hired employee health files. The ADON stated that one of her responsibilities was to assess their vital signs (blood pressure, heart rate, respiratory rate, height and weight). The ADON could not provide an explanation as to why the physician assessed the new hired employees after their DOH. The ADON also did not provide any further information if she assessed the newly hired	S1405	Employee # 6, DOH NJ Ex Order 26.4(had a NJ Ex Order 26.4(b)(1) NJ Ex Order 2. Employee # 7, DOH NJ Ex Order 26.4 had a NJ Ex Order 26.4(b)(1) . Employee #8 ,, DOH NJ Ex Order 26.4 had a NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4. No residents were adversly affected by this practice. All residents have the potential to be affected. The director of Nursing provided in-service education to the assistant director of Nursing on the N.J.A.C. 8:39-19.5 (a) which includes: if the new employee receives nursing assesment by a registered Professional nurse upon employment, The physician or advanced practice nurse examination may deffered for upmto 30 days of employment." The Director of Nursing and assistant director of Nursing immediately conducted an audit of 100 % of the medical files for newly hired employees in the last 30 days, to ensure a nursing assesment by a RN, Was completed upon employnment (Date of Hire.) The Director of Nursing will conduct audits 100 % of new hire employees to ensure that nursing assessment by a registered professional nurse has been performed upon employment. Audits will be conducted weekly x 4 weeks, then	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: _____ B. WING _____	C 08/13/2024

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

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S1405	Continued From page 8 employees prior to their DOH. According to N.J.A.C. 8:39 - 19.5: (a) "The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment." On 8/9/24 at 12:48 PM, the survey team met with the facility's Licensed Nursing Home Administrator, Director of Nursing and Regional Clinical Nurse #2. There was no further information provided. NJAC 8:39-19.5 (a)	S1405	monthly x 3 months then quarterly x 3 quarters. The result of all the audits will be provided monthly x 3 months, then quarterly x 3 quarters to the facility administrator and QAPI committe for review and comment. The QAPI committee meets on a monthly basis. The QAPI committee will review and determine for further audits.	

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
315468 Y1	A. Building B. Wing Y2	10/7/2024 Y3

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	Correction	ID Prefix F0655	Correction	ID Prefix F0658	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	08/16/2024	LSC	09/02/2024	LSC	09/02/2024
ID Prefix F0698	Correction	ID Prefix F0812	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed
LSC	09/02/2024	LSC	09/02/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/13/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
PSIFQU Y1	A. Building B. Wing Y2	10/7/2024 Y3

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 09/02/2024	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 08/15/2024	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	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
8/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING **01** B. WING _____	**08/13/2024**

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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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 8/13/24, was found not 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 exterior diesel generator does approximately 40 % of the building as per the Maintenance Director.	K 000		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		10/1/24

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

Electronically Signed | 09/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING **01** B. WING _____	**08/13/2024**

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K 321	Continued From page 1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/13/24 in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), it was determined that the facility failed to ensure hazardous areas were separated from other spaces by a fire barrier having at least a 1-hour fire resistance rating and self-closing or automatic-closing doors in accordance with NFPA 101:2012 edition, Section 19.3. This deficient practice had the potential to affect all residents in the facility and was evidenced for 2 of 2 day-room closet/offices by the following: 1). At 10:15 a.m., the surveyor and U.S. FO and U.S. FOIA (b) (6)) observed in the occupied day room by resident rooms 225 and 227, that the left and right side of the room was an office and a storage room. The rooms were provided with a partial wall that did not meet the ceiling. The openings were observed to be approximately 4-foot x 20-foot in size and the rooms contained combustible cardboard boxes. The occupied day room had 2	K 321	The Regional Environmental Director contacted the vendor for a quote to close in the partial wall separating the (2 of 2 Dayrooms) from closet/offices. No resident were negatively affected by this practive. All residents have the potential to be affected. The regional environmental director immediately contacted a vendor to obtain a quote to close in the partial wall separating the 2 of 2 dayrooms from the closet/offices. The environmental director or designed will conduct daily fire rounds on the day 2 dayrooms. Johnson Control will round quarterly to conduct fire safety rounds in the facility which will include rounds on the (2) Rooms. THe environmental Director or designee will conduct fire rounds daily on the two day roomson an ongoing basis until the partial walls are Extended to the ceiling to meet guidelines proposed. THe result of the audits/rounds will be provided to the administrator and the	

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	315468	A. BUILDING **01** B. WING _____	**08/13/2024**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 doorway openings to the exit/egress corridor that would allow for smoke, fire or fumes to pass directly to the exit/egress corridor. 2). At 10:15 a.m., the surveyor and U.S. FO and U.S. FOIA (b) (6)) observed in the occupied day room by resident rooms 110 and 112, that the left and right side of the room was an office and a storage room. The rooms were provided with a partial wall that did not meet the ceiling. The opening's were observed to be approximately 4-foot x 20-foot in size and the rooms contained combustible cardboard boxes. The occupied day room had 2 doorway openings to the exit/egress corridor, that would allow for smoke, fire or fumes to pass directly to the exit/egress corridor. In an interview at the time of the observations, the U.S. FO and U.S. FOIA (b) both stated and agreed, that the day rooms should have a smoke resistant partition to the ceiling to prevent smoke, fire or fumes to pass directly to the exit/egress corridor due to the amount of hazardous storage observed in each room. The rooms were greater then 50 sq ft. in size. The U.S. FOIA (b) (6) was informed of the findings at the Life Safety Code exit conference on 8/13/24. NJAC 8:39-31.2(e)	K 321	QAPI committee monthly until repair is complete. The QAPI committee meets monthly and will review the results of the audit rounds	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and	K 712		9/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING **01** B. WING _____	**08/13/2024**

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 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
K 712	Continued From page 3 unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and interview on 8/13/24 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to conduct in-house fire drills with varying activation types and simulation of emergency fire conditions in accordance with NFPA 101: 2012 Edition, Sections 19.7.1.4 through 19.7.1.7. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: A document review on 8/13/24 with the U.S. FOI[redacted] revealed the facility fire drill reports identified the method for the simulation of emergency fire conditions and alarm transmission signals were not specific to a location. Date: type of alarm transmission signal: Pull, Smoke or Page 7/27/24 no transmission signal type, no specific type of fire simulation used to train staff members. 6/4/24 no transmission signal type, no specific type of fire simulation used to train staff members. 5/11/24 no transmission signal type, no specific type of fire simulation used to train staff members.	K 712	The Environmental Director immediately Scheduled monthly fire drills, for the rest of the calendar year. The fire drills Will be held at expected and unexpected times under varying conditions. The days/shifts will alternate month to month so as the locations area/Pull station for the fire drill. No resident were negatively affected by this practce. All residents have the potential to be affected. The regional environmental Director provided in-Service re-education to the U.S. FOIA (b) (6) with regards to conducting in-house fire drills with varying activation types and simulation of emergency fire conditions in accordance with NFPA 101:2012 edition, sections 19.7.1.7. The environmental Director will conduct the monthly Fire Drills according to a schedule. The Fire Drills will be held at alternate times of the day/shifts. The Environmental Director will provide a copy of the monthly schedule for fire drills on alternate days/Shifts to the facility administrator and the Regional environmental director for review. The schedule will be provided to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING **01** B. WING _____	**08/13/2024**

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 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
K 712	Continued From page 4 4/4/24 no transmission signal type, no specific type of fire simulation used to train staff members. 3/13/24 no transmission signal type, no specific type of fire simulation used to train staff members. 2/17/24 no transmission signal type, no specific type of fire simulation used to train staff members. 1/22/24 no transmission signal type, no specific type of fire simulation used to train staff members. 12/14/23 no transmission signal type, no specific type of fire simulation used to train staff members. 10/18/23 no transmission signal type, no specific type of fire simulation used to train staff members. 9/17/23 no transmission signal type, no specific type of fire simulation used to train staff members. 8/20/23 no transmission signal type, no specific type of fire simulation used to train staff members. The findings were verified by the U.S. FO at the time of record review. The U.S. FO confirmed that the fire drills were not descriptive as to the type of device used to activate the fire alarm system, (pull, page and smoke) including the location and specific type of fire simulation used to train staff members on the above dates. The U.S. FOIA (b) (6) was informed of the findings, at the Life Safety Code exit conference on 8/13/24. NJAC 8:39-31.2(e)	K 712	administrator and regional environmental director monthly X3 months, Then Quarterly X3 quarters. The environmental Director will provide the employee sign in sheet for participation during monthly fire drills to the administrator and QAPI Committee monthly x 3 months then Quarterly x 3 quarters. The QAPI committee meets monthly and will review the results of the audit/rounds and evaluate the need for further audits.	

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 01 - MAIN BUILDING 01 B. Wing	10/7/2024

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 Reg. # NFPA 101 LSC K0321	Correction Completed 10/01/2024	ID Prefix Reg. # NFPA 101 LSC K0712	Correction Completed 09/12/2024	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
8/13/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO