

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/03/2025
NAME OF PROVIDER OR SUPPLIER CARING FOR LIFE ADULT DAY CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 120 EAST HALSEY ROAD PARSIPPANY, 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
M 000	Initial Comments Type of Survey: Monitoring/Follow-up to the 8/21/2024 audit survey conducted by the Office of the Inspector General. Census: Two Sessions: Morning 170 Afternoon 86 Sample Size: 11 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	M 000			
M 221	8:43F-3.1(a) Administration The license holder shall appoint an administrator who is a full-time employee of the facility. The administrator, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available on the premises of the facility during the hours when participant care services are being provided.	M 221			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/02/25

New Jersey Department of Health

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M 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the administrator, or the alternate adminsitator, failed to be available on the premises of the facility during the hours when participant care services were being provided. This deficient practice was evidenced by the following: On 9/3/25 at 9:00 a.m., upon entrance to the facility, the surveyor requested to speak with the Administrator and was told that the Administrator was not present in the building. The surveyor asked to speak to the alternate Administrator or whoever was in charge, the Receptionist stated that there was no one in charge at the time. The surveyor observed participants walking around the foyer and hallways of the facility as well as some sitting on couches in the foyer. At 9:02 a.m., the surveyor interviewed the Receptionist and a Registered Nurse (RN) regarding why there was no one in charge of the facility. The Receptionist stated that there was no one in charge and that the surveyor needed to leave, call the facility, and come back when the surveyor had made an appointment. The RN stated that he/she did not know why there was no one in charge and shrugged his/her shoulders. At 9:11 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN), regarding who was currently in charge of the facility. The LPN stated that he/she did not know who was in charge. The surveyor again stated the need to speak with someone in charge. At 9:25 a.m., the surveyor interviewed the Administrator, who had just arrived, about who	M 221			

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M 221	Continued From page 2 was in charge when participants were present, the Administrator stated that she had been in traffic and that there was someone present in the facility who was in charge. In the same interview, the Administrator stated that the Director of Social Work was her alternate and that she was present in the building, but did not know why the staff did not know who was in charge. At 12:25 p.m., the surveyor reviewed an undated policy and procedure document titled, "Administrator". "Policy Interpretation and Implementation [:] ...2. The Administrator shall be available on the premises during the hours when participant care services are being rendered. 3. In the absence of the Administrator, the Director of Social Work in conjunction with the business office manager is authorized to act on the Administrator's behalf..."	M 221			
M 237	8:43F-3.3(d)(2) Administration (d) A policy and procedure manual(s) for the organization and operation of the facility shall be developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following: 2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and participant care services of the facility.	M 237			

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M 247	Continued From page 4 developed, implemented, and reviewed at intervals specified in the manual(s). Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility to representatives of the Department at all times. The manual(s) shall include at least the following: 7. Policies and procedures, including content and frequency, for physical examinations upon employment and subsequently for employees and for other persons providing direct care services to participants. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that a) the facility failed to review and update their Policy and Procedure manual and b) the facility failed to review the "Infection Prevention and Control" policy on a yearly basis. This deficient practice was evidenced by the following: 1. On 9/3/25, at 10:04 a.m., the surveyor reviewed the facility's Policy and Procedure manual. The surveyor did not observe any documented evidence of the Policy and Procedure manual being reviewed or updated. The surveyor reviewed an undated policy titled, "Infection Control Program" that was found in the Policy and Procedure manual. There was no documented evidence that the policy and procedure was reviewed and/or updated yearly.	M 247			

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M 247	Continued From page 5 At 12:31 p.m., during surveyor interview, when asked about the Policy and Procedure manual not being reviewed or updated yearly, the Administrator confirmed that the policies and procedures should be reviewed. 2. On the 8/21/24 Office of the Inspector General survey, there was no documented evidence of the Policies and Procedure manual being reviewed or updated. When the surveyors asked about the manual review and updates, the Administrator stated that they did not review or update the manual but rely on the medical record practitioner to suggest any updates to the manual. In reference to the "Infection Control" policy, the policy was available in the manual for review, but the policy was not reviewed annually.	M 247			
M 419	8:43F-6.3(d) General Services The facility shall maintain written staffing schedules. Staffing schedules shall be implemented to ensure continuity of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to maintain written staffing schedules to ensure continuity of care. This deficient practice was evidenced by the following: 1. On 9/3/25 the surveyor conducted a monitoring survey. At 9:25 a.m., the surveyor interviewed the Administrator regarding staffing schedules and	M 419			

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M 419	Continued From page 6 requested documentation of the facility's staffing schedule for the previous three (3) months. At 11:14 a.m., the Adminstrator provided written staff schedules from the previous 3 months. At 12:10 p.m., the surveyor reviewed two facility policies titled, "Mandatory Staffing Schedule" and "Staffing" that indicated how many and which staff are needed, depending on the facility's census, but there was no documentation regarding maintaining a staffing schedule. At 12:31 p.m., the surveyor interviewed the Adminstrator about not providing written documentation during the previous survey, the Administrator stated she did not have a written staff schedule at the time. 2. On 8/21/24, during the Office of the Inspector General (OIG) survey, the surveyors requested a staffing schedule and the Administrator stated that the facility did not maintain written staffing schedules.	M 419		
M 421	8:43F-6.3(e)(1)(i) General Services (e) The facility shall develop and implement a staff orientation plan and a staff training and education plan, including plans for each service and designation of person(s) responsible for ongoing training. 1. All staff shall receive orientation at the time of employment and ongoing in-service training regarding, at a minimum, emergency plans and procedures, the infection prevention and control services, participant	M 421		

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M 421	Continued From page 7 rights, and elder abuse. i. The facility shall document ongoing in-service training of all staff. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to provide ongoing annual in-service training on participant rights, emergency plans, infection control and elder abuse for 11 of 11 employees, Employee #s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11. This deficient practice was evidenced by the following: 1. On 9/3/25, at 10:04 a.m., the surveyor reviewed personnel files for eleven employees, Employee #'s 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, and 11. The surveyor observed that there was no documented evidence for the 11 of 11 employees having received ongoing annual in-service training in participant rights, emergency plans, infection control, and elder abuse since their new hire orientation. At 10:39 a.m., the surveyor reviewed the in-service binder and revealed the last three drills conducted by the facility: "Patient Safety" on 3/14/25, "TB (Tuberculosis) Control and Prevention" on 12/3/24 and "Safety Measures at the Day Care Center" on 11/6/24.	M 421			

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M 421	Continued From page 8	M 421			
	2. During the 8/21/24 Office of the Inspector General (OIG) survey, there was no documented evidence provided on the ongoing annual in-service trainings on participant rights, emergency plans, infection control and elder abuse for 2023 and 2024.				
M 425	8:43F-7.1(a) Nursing Services A registered professional nurse shall be designated in writing as the director of nursing services and shall be on duty at all times when participants are present in the facility. A registered professional nurse shall be designated in writing to act in the director's absence. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that a registered professional nurse was designated in writing to act in the absence of the Director of Nursing (DON). This deficient practice was evidenced by the following: 1. On 9/3/25 at 10:04 a.m., the surveyor reviewed a 1/17 facility policy titled, "Designation of Director of Nursing Services" which revealed "...A registered professional nurse shall be designated in writing to act in the director's absence ..." At 1:31 p.m., when the surveyor asked about the alternate DON, the Administrator stated that the alternate DON was hired on [REDACTED] NJ Exec Order 26:401. In the	M 425			

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M 425	Continued From page 9 same interview, the surveyor asked if the alternate DON was documented in writing, the Administrator stated that she would provide it. At 2:30 p.m., the Administrator provided the surveyor with written documentation of the name of the alternate (DON) and the date the staff was hired into that position. 2. In reviewing the documentation in the facility's policy and procedure manual on 9/3/25 and during the 8/21/24 Office of the Inspector General (OIG) survey, the facility failed to ensure there was an alternate DON in writing prior to [REDACTED]	M 425		
M 685	8:43F-14.17(d) Physical Plant Requirements The emergency plans, including a written evacuation diagram specific to the unit that includes evacuation procedure, location of fire exits, alarm boxes, and fire extinguishers, and all emergency procedures shall be conspicuously posted throughout the facility. All employees shall be trained in procedures to be followed in the event of a fire and instructed in the use of fire-fighting equipment and evacuation as part of their initial orientation and at least annually thereafter. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, it was determined that the facility failed to provide staff training in procedures to be followed in the event of a fire and fire-fighting equipment, and evacuation as part of their initial orientation	M 685		

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M 685	Continued From page 10 and at least annually thereafter. This deficient practice was evidenced by the following: 1. On 9/3/25 at 10:04 a.m., the surveyor reviewed the fire drill training log. The surveyor observed that the facility conducted fire drills three times in 2024 and one time in 2025. The surveyor also observed that the documented fire drills included evacuating participants and staff in the event of a fire. There was no documented evidence provided of any staff training regarding the use of fire-fighting equipment and no documented evidence that the facility conducted any other type of emergency disaster drills in 2024 or 2025. At 12:31 p.m., during surveyor interview, when asked about the staff training in the use of fire-fighting equipment, the Administrator stated that she did not know that it was required and that she was unsure on how to train facility staff. 2. During the 8/21/24 Office of the Inspector General (OIG) survey, the surveyors reviewed the emergency drill documents and there was no documented evidence of yearly trainings on the procedures to follow in case of a fire and using fire-fighting equipment.	M 685			
M 689	8:43F-14.17(f)(g) Physical Plant Requirements (f) Drills of emergency plans shall be conducted at least four times a year and documented, including the date, hour, description of the drill, participating staff, and signature of the person in charge. The four drills shall include at least one drill for emergencies due to fire. (g) The facility shall conduct at least one drill per year for emergencies due to another type of	M 689			

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M 689	Continued From page 11 disaster, such as storm, flood, other natural disaster, bomb threat, or nuclear accident. All staff shall participate in at least one drill annually, and program participants may take part in drills. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, it was determined that a) the facility failed to conduct drills of emergency plans at least four (4) times each year, with at least one (1) of the drills for emergencies due to fire and b) the facility failed to conduct at least one (1) drill a year for emergencies due to another type of disaster, such as storm, flood, bomb threat, or other natural disaster. This deficient practice was evidenced by the following: 1. On 9/3/25 at 11:55 a.m., the surveyor reviewed an undated policy titled, "Emergency Drills", which revealed "Policy Statement [The Facility] performs simulated emergency drills of emergency plans, one on each shift at least four times a year. Policy Interpretation and Implementation [:]... 2. At least one emergency drill per year shall be due to fire. 3. At least one drill per year shall be due to another type of emergency such as a storm, flood, other natural disaster, bomb threat, or nuclear accident. 4. All staff and participants shall participate in at least one drill annually. 5. A documented record is maintained of each drill. These records include the date, hour, type, and description of the drill,	M 689			

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M 689	Continued From page 12 participating staff, and the signature of the person in charge of the drill." At 12:05 p.m., the surveyor reviewed the facility's training log. The surveyor observed documented evidence that the facility conducted three fire drills in 2024 and one in 2025. The surveyor did not observe any documented evidence that the facility conducted any other type of emergency disaster drills in 2024 or 2025. At 12:31 p.m., the surveyor interviewed about the frequency of the drills (not having 4 in a year) and that there was no other documented emergency drills, the Administrator stated that she did not have an answer. 2. During the 8/21/24 Office of the Inspector General (OIG) survey, the facility had only conducted three fire drills in 2023 and there was no documented evidence on drills for other types of disasters.	M 689			
M 813	8:43F-16.7(a)(1-23) Infection Control, Santation, Housekeeping (a) The following housekeeping, sanitation, and safety conditions shall be met: 1. The facility and its contents shall be free of dirt, debris, and insect and rodent harborages; 2. Nonskid wax shall be used on all waxed floors; 3. All rooms shall be ventilated to help prevent condensation, mold growth,	M 813			

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M 813	Continued From page 13 and noxious odors; 4. All participant areas shall be free of noxious odors; 5. Throw rugs or scatter rugs shall not be used in the facility; 6. All furnishings shall be clean and in good repair, and mechanical equipment shall be in working order. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection. Broken or worn items shall be repaired, replaced, or removed promptly; 7. All equipment shall have unobstructed space provided for operation; 8. All equipment and materials necessary for cleaning, disinfecting, and sterilizing shall be provided; 9. Thermometers which are accurate to within three degrees Fahrenheit shall be maintained in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration; 10. Pesticides shall be applied in accordance with N.J.A.C. 7:30; 11. Articles in storage shall be elevated from the floor and away from walls; 12. All poisonous and toxic materials shall be identified, labeled, and stored in a locked cabinet or room that is used for	M 813		

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M 813	Continued From page 14 no other purpose; 13. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement; 14. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored in closed metal cabinets or containers; 15. Unobstructed aisles shall be provided in storage areas; 16. A program shall be maintained to keep rodents, flies, roaches, and other vermin out of the facility; 17. Toilet tissue, soap dispenser, paper towels or air dryers, and waste receptacles shall be provided in each bathroom at all times; 18. All solid or liquid waste that is not regulated medical waste, garbage, and trash shall be collected, stored, and disposed of in accordance with the rules of the New Jersey Department of Environmental Protection and the New Jersey Department of Health and Senior Services. Solid waste shall be stored in insect-proof, rodent-proof, and fire-proof, non-absorbent, watertight containers with tight-fitting covers and collected from storage areas regularly, so as to prevent nuisances such as odors. Procedures and schedules shall be established and implemented for the cleaning of storage areas and containers for solid or liquid waste, garbage, and trash, in	M 813			

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M 813	Continued From page 15 accordance with N.J.A.C. 8:24; 19. Garbage compactors shall be located on an impervious pad that is graded to a drain. The drain shall be unobstructed and connected to the sanitary sewage disposal system; 20. Plastic bags shall be used for solid waste removal. Bags shall be of sufficient strength to safely contain waste from point of origin to point of disposal and shall be effectively closed prior to disposal; 21. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof; 22. Wastebaskets and ashtrays shall be made of noncombustible materials; 23. Latex foam pillows shall be prohibited. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the safety of its participants by having throw rugs in the entrance of the facility. This deficient practice	M 813			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/03/2025
NAME OF PROVIDER OR SUPPLIER CARING FOR LIFE ADULT DAY CARE, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 120 EAST HALSEY ROAD PARSIPPANY, NJ 07054		
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M 813	Continued From page 16 was evidenced by the following: 1. On 9/3/25 at 9:00 a.m., the surveyor observed three green throw rugs covering the floor of the front entrance to the facility. At 9:25 a.m., when the surveyor asked about the throw rugs at the front entrance of the facility, the Administrator stated that the rugs ensured the safety of the facility's participants for when it was raining or snowing outside, so that the mats helped dry the participants' shoes when they walked into the facility in order not to slip on a wet floor. 2. On 8/21/24, during the Office of the Inspector General (OIG) survey, the surveyors observed throw rugs in the front entrance of the facility.	M 813			

CARING FOR LIFE ADULT DAY CARE, LLC

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Received
&
Accepted
2/11/26

FACILITY: CARING FOR LIFE ADULT DAY CARE

SURVEY DATE: September 3, 2025

Provider's Plan of Correction:

St - M - 0221 - 8:43f-3.1(a) – Administration

(Element # 1) Please specify who educated the receptionist and when.

The administrator has educated the receptionist following the survey visit on September 3rd. After the organizational chart and directory was updated by the Administrator, the receptionist was educated again on December 8th.

(Element # 2) Do the participants have the potential to be affected by this deficient practice?
Yes, all participants have potential to be affected.

(Element # 3) Who is the Alternate Administrator? When was written documentation placed in the policy and procedure manual? Please specify when staff were educated and by whom.
There is written documentation of an Alternate Administrator, Director of Social Work, in the Policy and Procedure manual and will continue to be updated as needed. It was placed in the policy and procedure manual after the survey on September 3rd. Staff was educated on the Alternate Administrator by the Administrator on December . When organizational chart was updated on December 8th, an in-service meeting was done with the staff discussing the chart and the Alternate Administrator.

(Element # 4) Please specify when the update began and if it will be audited to ensure continued compliance. How often will the audits occur?
Updates began December 8th and will continue to be monitored the first of every month. Training will continue when changes are made but otherwise is set for the next quarter. Audits will be conducted on a quarterly basis by the Administrator.

Completion Date: December 8, 2025

St - M - 0237 - 8:43f-3.3(d)(2) – Administration

(Element # 1) Please specify the date that the organizational chart was created. Please specify the date that the organizational chart was placed into the policy and procedure manual and by whom.
The organizational chart was initially created when the day care first opened in 2018 and was recently updated on December 8th and placed thereafter in the policy and procedure manual by the Administrator.

(Element # 2) Do the participants and staff have the potential to be affected by this deficient practice?
Yes, all participants and staff have potential to be affected.

(Element # 3) What measures will be put into place to ensure the deficient practice is corrected?
Updates will ensure on a monthly basis by the Administrator. Training will occur when any changes are made to the organizational chart by the administrator and if no changes are made, a quarterly training will continue to review the organizational chart. Training started December 8th.

(Element # 4) How will the corrective actions be monitored and ensured not to reoccur? Will audits be conducted to ensure continued compliance? If so, how often? Who will monitor the corrective measures? Who will audit for continued compliance?

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Audits will be conducted on a quarterly basis by the Administrator to ensure everything is up to date and in compliance.

Completion Date: December 8, 2025

St - M - 0247 - 8:43f-3.3(d)(7) – Administration

(Element # 1) Please specify who reviewed the Policy and Procedure Manual and when it was reviewed. Please specify who reviewed the Infection Control policy and when it was reviewed. Were the policies revised? If so, please specify the date they were revised.

The administrator reviewed the Policy and Procedure Manual on December 8th. Infection control was reviewed by Administrator and the Director of Nursing on December 8th. There were no revisions but will be updated as needed within the next quarterly audit/ review.

(Element # 2) Do all participants and staff have the potential to be affected?

Yes, all participants have potential to be affected.

(Element # 3) Please specify the date that the yearly log was created. What trainings were conducted? When and by whom?

Administrator created the yearly log in December 8th to keep track of Policy and Procedure Manual review. The Policy and Procedure manual was created before the center was opened in 2018. As to ensure compliance and auditing moving forward, the Administrator will continue to update the Policy and Procedure Manual as needed and reviewed yearly. Yearly review will be completed annually.

(Element # 4) How will the corrective measures be monitored? Will audits be conducted to ensure continued compliance? If so, how often?

Audits will be started on December 8th and conducted on a quarterly basis by the Administrator to ensure everything is up to date and in compliance.

Completion Date: December 8, 2025

St - M - 0407 - 8:43f-6.3(a) - General Services

(Element # 1) How the corrective action will be accomplished for those staff affected by the deficient practice. Please specify for each individual employee and their status at the facility. Please specify dates of each background check or dates to be scheduled as well as who is scheduling. Please specify each date of the physical exams. Please specify dates of each reference check.

All employee's background check if not found, was submitted for another background check will be completely updated and filed by the end of the month. Employee #3 background check was resubmitted NJ Exec Order 26.4b1. Employee #6 background check was resubmitted NJ Exec Order 26.4b1. The administrator will be scheduling background checks moving forward and will update it as needed.

(Element # 2) Do all participants and staff have the potential to be affected?

Yes, all participants have potential to be affected.

(Element # 3) What measures will be implemented to ensure the deficient practice does not reoccur?

Any training conducted for staff who will be updating and monitoring employee files?

A audit will be conducted on a quarterly basis to ensure everyone is updated. Administrator will be updating and monitoring employee files moving forward.

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(Element # 4) Who will monitor the employee files? Who will update the employee files? Will audits be conducted to ensure continued compliance? Who will conduct the audits? How often? When will the audits be effective?

Audits will be conducted on a quarterly basis by the Administrator. The administrator will monitor all employee files moving forward and will update the files as needed.

Completion Date: December 31, 2025

St - M - 0419 - 8:43f-6.3(d) - General Services

(Element # 1) Please specify the date that the staffing schedules were created and by whom. Staff schedule initially was first created when facility opened in 2018. Written staffing schedules were updated December 8th. Staff will follow administrator's written schedule based on but can be subject to change upon day to day events. In that case, the written schedule will be updated based on any last minute changes.

(Element # 2) Do participants and staff have the potential to be affected by this deficient practice? Yes, all participants have potential to be affected.

(Element # 3) Who will be creating the staff schedules and how often? Were any trainings conducted to staff in creating schedules, reading schedules, or knowing where the schedules are posted? The administrator will be responsible to make sure a monthly schedule is available. It will be created on a monthly basis. Staff were notified that the schedule can be found with the administrator and if anything was to change, to notify administrator immediately.

(Element # 4) Who will be monitoring the staff schedules? Will audits be conducted to ensure continued compliance? If so, how often? Who will conduct the audits?

Staff schedule will be monitored by the administrator and audits will be conducted on a quarterly basis by the Administrator.

Completion Date: December 8, 2025

St - M - 0421 - 8:43f-6.3(e)(1)(i) - General Services

(Element # 1) Please specify each the topic of each in-service and the date of the in-service for each employee. Who provided the education? What is the current status for each employee?

All employee #'s 1,2,3,4,5,6,7,8,9,10, and 11 are all still currently employed. On December 8th in-service was conducted by the administrator and all employee #'s 1,2,3,4,5,6,7,8,9,10, and 11 were present. Inservice regarding participants rights, scheduling, organizational chart, fire drill protocols, emergency plans, infection control and elder abuse is up to date with all employees.

(Element # 2) Do all participants and staff have the potential to be affected by this deficient practice? Yes, all participants and staff have potential to be affected.

(Element # 3) Please provide dates for when the next trainings will be and how often they will occur. Please specify who will be teaching and who will be educated.

Training will be conducted every 3-4 months. The next training will be conducted in March 2026. The Administrator and Director of Nursing will be conducting training.

(Element # 4) Please specify who will be monitoring and how it will be monitored. Please specify the date that the monitoring started. Will audits be conducted to ensure continued compliance? If so, when and how often?

Monitoring will start after this year's review on December 8th by the administrator. Training/ in-services will be part of a quarterly audit conducted by the administrator.

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Completion Date: December 8, 2025

St - M - 0425 - 8:43f-7.1(a) - Nursing Services

(Element # 1) Please specify who the Alternate Director of Nursing. Please specify Alternate Director of Nursing hire date. Please specify date that written documentation of who the Alternate Director of Nursing was placed into the Policy and Procedure Manual and the employee file.

By December 8th, the written notification of the alternate Director of Nursing, a Registered Nurse, was placed in the policy and procedure manual. Alternate Director of Nursing was hired in 2019 but was not assigned Alternate Director until May 2025.

(Element # 2) Do all participants have the potential to be affected by this deficient practice?

Yes, all participants have potential to be affected.

(Element # 3) Please specify who will be updating the Policy and Procedure Manual and the employee files. Please specify measures to ensure deficient practice does not reoccur.

The letter was confirmed in the policy and procedure manual by December 8, 2025. Policy and Procedure as well as employee files will be updated by the Administrator moving forward. To avoid future deficiencies, updated signature of quarterly review will be required.

(Element # 4) Please specify who will review and monitor written documentation regarding alternates to various positions will be updated in the Policy and Procedure Manual and employee files. Please advise the date that the monitoring started. Please specify if audits will be conducted to ensure continued compliance. If so, how often? Who will be conducting the audits?

The administrator will make sure any updates in the policy and procedure manual and employee files will be reviewed and monitored. Audits will be conducted quarterly and annual review will start December 8, 2025.

Completion Date: December 8, 2025

St - M - 0685 - 8:43f-14.17(d) - Physical Plant Requirements

(Element # 1) Please specify dates and types of in-services held for staff. Please specify who educated during the in-services.

A person from the fire department is requested to assist in conducting professional fire training with all staff suggested to attend. As the date is currently being discussed with the fire department, mandatory meetings will occur discussing fire safety and procedures should a fire event occur in the facility. The last fire safety in-service was held in December. The administrator will be alongside to assist in conducting the services held. Dates will be posted in the employee area.

(Element # 2) Do all participants and staff have the potential to be affected by this deficient practice. Yes, all participants and staff have potential to be affected.

(Element # 3) Please specify the date the request was sent to the fire department. Please specify dates in-services will be held and how often. Who will be educating at the in-services and what staff will be educated? Also, please specify what types of in-services to be held.

A message was relayed to the fire department December 15th to have a professional come in for training. A follow up message will be requested if no message is returned. In-service and safety training will be held every 3-4 months by the administrator, last being held in December. In-services will range from basic yearly training to up to date knowledge on safety and care for the elderly.

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(Element # 4) Who will be monitoring the in-services? Will audits be conducted to ensure continued compliance? If so, how often? Who will conduct the audits?

Audits will be conducted quarterly. The first drill for next year will start in January.

Administrator will be monitoring all activities.

Completion Date: December 15, 2025

St - M - 0689 - 8:43f-14.17(f)(g) - Physical Plant Requirements

(Element # 1) Please specify the dates in-services were conducted and by whom. Please specify the type of in-service conducted.

Administrator will be in charge of conducting the drills. These drills will be discussed with the Director of Nursing as well as the Alternate Administrator to see what drills are important to practice. This will then be planned and implemented starting January 5, 2026. A fire drill was conducted at the end of September and October, and one beginning of December. The last in-service/ drill was conducted December 5th by the administrator on flooding.

(Element # 2) Do all participants and staff have the potential to be affected by this deficient practice? Yes, all participants and staff have potential to be affected.

(Element # 3) How will drills be documented? Will employees be required to sign their names? Who will conduct the drills?

Drills will be planned and written out by the administrator and require attended staff to sign their names.

(Element # 4) Who will monitor to ensure that in-services entail various types of emergencies and are documented? Who will update the in-service manual to maintain the in-service documentation? Will audits be conducted to ensure continued compliance? If so, how often? Who will conduct the audits? Administrator and the Director of Nursing will ensure that in-services will entail various types of emergencies and administrator will document and update as necessary. Audits for these drills will be part of the quarterly audit update conducted by the Administrator.

Completion Date: December 8, 2025

St - M - 0813 - 8:43f-16.7(a)(1-23) - Infection Control, Sanitation, Housekeeping

(Element # 1) Please specify the date in which the throw rugs were removed from the entrance of the facility. Please specify who removed the throw rugs.

After the survey, the rugs were taped down to the floor when in use but the throw rugs has since been removed starting December 8th by the administrator.

(Element # 2) Do all participants have the potential to be affected by this deficient practice? Yes, all participants and staff have potential to be affected.

(Element # 3) Have staff been educated regarding the need to remove the throw rugs? If so, please specify date and by whom. What corrective measures are being implemented?

Yes, staff has been informed about the potential removal of throw rug by the administrator the day of survey and reiterated the day it was removed on December 8th. The receptionist and drivers were informed that upon entrance, the staff are required to help patients into the building.

(Element # 4) Please specify who will monitor the corrective measures to ensure the deficient practice is being corrected. Please specify the date the monitoring began and how often it will be monitored.

The administrator will enforce staff to assist participants upon entry. Monitoring started December 8th and will be continuously monitored on a day to day basis by the administrator.

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Completion Date: December 8, 2025

St - M - 0821 - 8:43f-17.1(a)(1) - Transportation Services

(Element # 1) Please specify the date that the vehicle information was obtained and by who. Please specify who created the shared log.

After the survey, information was requested so a log can be created. By December 15th, Vehicle information has been created and started being obtained by the administrator. Full information is still being obtained but will be fully gathered by December 31, 2025.

(Element # 2) Do all the participants have the potential to be affected by this deficient practice? Yes, all participants and staff have potential to be affected.

(Element # 3) Please specify the start date of the shared log. Please specify the date of the driver checklist and the contents of the checklist started. Please specify who is responsible for the annual fire extinguisher inspection.

The shared log was officially created December 15th and is still being worked on. After the survey, drivers were requested to run through a checklist in the morning before their pick-ups. The driver checklist was officially started on December 15th. Administration obtaining the report will be either the Administrator or Administrative assistant. Annual fire extinguisher inspection will be in the responsibility of the administrator to monitor.

(Element # 4) Please specify who will monitor the log and checklists to ensure continued compliance. Will audits be conducted? If so, how often and by whom?

The administrator and Administrative assistant will be monitoring the logs and checklists. Audits will be conducted quarterly as well by the administrator.

Completion Date: December 31, 2025

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/11/2026
NAME OF PROVIDER OR SUPPLIER CARING FOR LIFE ADULT DAY CARE, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 120 EAST HALSEY ROAD PARSIPPANY, 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
{M 000}	Initial Comments Type of Survey: Monitoring/Follow-up to the 8/21/2024 audit survey conducted by the Office of the Inspector General. Census: Two Sessions: Morning 170 Afternoon 86 Sample Size: 11 The facility was not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:43F, Standards for Licensure of Adult Day Health Services. 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 New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	{M 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

12/02/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 14015	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/11/2026
NAME OF FACILITY CARING FOR LIFE ADULT DAY CARE, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 120 EAST HALSEY ROAD PARSIPPANY, 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 M0221	Correction	ID Prefix M0237	Correction	ID Prefix M0247	Correction
Reg. # 8:43F-3.1(a)	Completed	Reg. # 8:43F-3.3(d)(2)	Completed	Reg. # 8:43F-3.3(d)(7)	Completed
LSC	12/08/2025	LSC	12/08/2025	LSC	12/08/2025
ID Prefix M0407	Correction	ID Prefix M0419	Correction	ID Prefix M0421	Correction
Reg. # 8:43F-6.3(a)	Completed	Reg. # 8:43F-6.3(d)	Completed	Reg. # 8:43F-6.3(e)(1)(i)	Completed
LSC	12/31/2025	LSC	12/08/2025	LSC	12/08/2025
ID Prefix M0425	Correction	ID Prefix M0685	Correction	ID Prefix M0689	Correction
Reg. # 8:43F-7.1(a)	Completed	Reg. # 8:43F-14.17(d)	Completed	Reg. # 8:43F-14.17(f)(g)	Completed
LSC	12/08/2025	LSC	12/08/2025	LSC	12/08/2025
ID Prefix M0813	Correction	ID Prefix M0821	Correction	ID Prefix	Correction
Reg. # 8:43F-16.7(a)(1-23)	Completed	Reg. # 8:43F-17.1(a)(1)	Completed	Reg. #	Completed
LSC	12/08/2025	LSC	12/31/2025	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 9/3/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			