STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, NJ 07054

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Complaint #182228Based on observation, interview, record review, and review of facility-provided documentation, it was determined that the facility failed to ensure that incontinence care was provided to dependent residents in a timely manner for 2 of 5 residents (Residents #12 and #80) observed for incontinence care on 1 of 2 Nursing units (Wing 2).This deficient practice was evidenced by the following: On 4/6/26 at 7:15 AM, the surveyor conducted an incontinence tour on Wing 2 Nursing Unit and observed the following: On 4/6/26 at 7:25 AM, the surveyor, accompanied by the Certified Nursing Assistant #1 (CNA #1), observed Resident #80 in bed. CNA #1 exposed Resident #80's incontinence brief and observed a second incontinence brief in place, both were saturated with urine. CNA #1 confirmed that the two briefs were saturated and that the resident should not have had two briefs on. At that same time, Resident #80 stated that they had not been changed since last night and had not requested to have two briefs. The surveyor reviewed the medical record for Resident #80. A review of the admission Record (AR) or face sheet (an admission summary) reflected that Resident #80 was admitted to the facility with diagnoses that included but were not limited to, pressure ulcer of the sacral region (lower back) stage 3 (full-thickness skin loss) and malignant neoplasm of the breast. A review of the Annual Minimum Data Set (MDS), an assessment tool, reflected that the resident had a brief interview for mental status (BIMS) score of 13 out of 15, indicating the resident was cognitively intact. The MDS further assessed that Resident #80 was always incontinent of bowel and bladder and required staff assistance for personal hygiene. A review of Resident #80's Care Plan (CP) had a focus area which indicated that the resident was incontinent of urine and stool, with interventions that included the following:Encourage the resident to use the toilet upon awakening, after meals, nightly, and when neededMonitor for skin irritation and report as indicatedProvide skin care after each incontinence episode and apply a moisture barrierProvide verbal cues and physical assistance as neededPT/OT (Physical Therapy/Occupational Therapy) as needed. There was no documentation indicating that Resident #80 requested two adult incontinence briefs. 2. On 4/6/26 at 7:30 AM, Resident #12 approached the surveyor and CNA #1 in the hallway on Wing 2 Nursing unit and asked to have their diaper changed. The surveyor observed that the resident's clothing was heavily soiled and disheveled. CNA #1, the surveyor, and Resident #12 entered the resident's room. CNA #1 exposed Resident 12's incontinence brief, which was down by their knees and heavily soiled with copious amounts of dried and wet feces. The surveyor observed that the resident had a urinary catheter in place. The resident told CNA #1 that they had not had their brief or clothing changed since Saturday. The CNA confirmed that the brief was heavily soiled with feces and that it did not appear the resident had received care recently. The surveyor reviewed the medical record for Resident #12. A review of the AR reflected that Resident #12 was admitted to the facility with diagnoses that included but were not limited to, bipolar disorder, neuromuscular dysfunction of bladder (nerve damage causing urinary urgency or urinary retention) and the need for assistance with personal care. A review of the Quarterly MDS, with an assessment reference date of 3/3/26, reflected that Resident #12 had a BIMS score of 14 out of 15, indicating the resident's cognition was intact. Further review of the MDS indicated that the resident had no behaviors of rejecting assistance with care, had an indwelling urinary catheter, and was frequently incontinent of their bowels. A review of Resident #12's CP had a (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	focus area which included that the resident was incontinent of their bowels with interventions that included but were not limited to assist the resident with perineal care as needed. On 4/6/26 at 8:10 AM, during an interview with the surveyor, the Licensed Practical Nurse/Unit Manager (LPN/UM) for Nursing Units Wing 1 and Wing 2 confirmed that staff should provide incontinence care every two hours on all shifts and that if a resident refused incontinence care, the CNA should inform the nurse. The LPN/UM confirmed that she had not been informed that Resident #12 had refused care. On 4/6/26 at 11:00 AM, during an interview with the surveyor, the Director of Nursing (DON) confirmed that incontinence care should be provided every two hours on every shift and that if Resident #12 had refused incontinence care, the 11-7 CNA should have informed the nurse. On 4/8/26 at 10:12 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON to discuss the above observations and concerns. On 4/9/26 at 7:56 AM, the surveyor attempted a phone interview with the 11:00 PM-7:00 AM Certified Nursing Aide #2 (CNA #2). CNA #2 did not return the surveyor's call. On 4/9/26 at 8:10 AM, during an interview with the surveyor, CNA #1 stated that Resident #12 never refused care and always allowed her to assist them with incontinence care. A review of the facility's Activities of Daily Living (ADLs), Supporting reflected .Residents are provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out ADLs .Residents who are unable to carry out ADLs independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way, at a different time, or having another staff member speak with the resident may be appropriate. On 4/9/26 at 1:06 PM, no further information was provided by the LNHA. NJAC 8:39-27.1 (a), 27.2 (h)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, review of medical records, and other pertinent documentation, it was determined that the facility failed to ensure that the resident received care consistent with professional standards of practice to prevent pressure ulcers and promote healing by failing to, a.) ensure that the pressure reducing low air loss mattress was set according to resident's body weight for 1 of 3 residents (Resident #5) and b.) administer treatment according to physician order and document for 1 of 3 residents (Resident #49). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1.On 4/2/26 at 11:30 AM and 4/8/26 at 8:20 AM, Surveyor #1 (S #1) observed Resident #5 in bed with a specialty mattress in place. The resident's air mattress pump was set to a weight of 220 pounds (lbs). The surveyor reviewed the electronic medical record (EMR) for Resident #5. A review of the admission Record (AR) or face sheet (an admission summary) for Resident #5 reflected the resident was admitted with diagnoses that included but were not limited to, fracture of the right femur (break in the thigh bone) and dementia (a progressive decline in mental ability, such as memory and reasoning). A review of the admission Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 1/27/26, indicated that Resident #5 had a brief interview for mental status (BIMS) score of 12 out of 15, indicating moderate cognitive impairment. The MDS further indicated that the resident weighed 100 lbs, was at risk for developing a pressure ulcer, and had a pressure-reducing device on their bed. A review of the resident's most recent weight on 4/7/26 was 100.7 lbs. A review of the current Order Summary Report (OSR) reflected a physician's order (PO) for a low-air-loss mattress, with the function to be checked every shift. A review of the current electronic Treatment Administration Record (eTAR) included documentation indicating that the specialty mattress was monitored for function by nurses every shift. A review of Resident #5's Care Plan (CP) indicated the resident was at risk for alteration in skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	integrity with interventions that included but were not limited to preventative skin measures as ordered. The above CP interventions did not include a low-air-loss mattress. On 4/9/26 at 10:20 AM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The DON confirmed that the specialty mattresses were ordered for residents with pressure ulcers or at high risk of skin breakdown, and that it was the nurses' and CNAs' (Certified Nursing Aide's) responsibility to ensure the mattress pumps were set to the appropriate weights. A review of the facility's Air Mattress (Pressure Redistribution Surface Policy, dated 5/1/25, reflected .Compliance with New Jersey and federal regulations by providing appropriate use, monitoring, and management of air mattresses (pressure redistribution surfaces) to prevent and treat pressure injuries in nursing homes.Set mattress according to the resident's weight per manufacturer guidelines.Verify mattress function and settings at least once per shift.Responsibility of licensed nurses: assessment, care planning, monitoring, and documentation. On 4/9/26 at 1:06 PM, no further information was provided by the LNHA. 2. On 4/6/26 at 10:25 AM, Surveyor #2 (S #2) interviewed Resident #49 in the resident's room while the resident was lying in bed. The resident reported no concerns with skin breakdown and stated the resident had been in the facility for three years. A review of the AR indicated that the resident had diagnoses which included, but were not limited to; congestive heart failure, atrial fibrillation, morbid obesity, chronic obstructive pulmonary disease, and muscle weakness. A review of the quarterly MDS, with an ARD of 3/26/26, indicated Resident #49 had a BIMS score of 15 out of 15, indicating the resident was cognitively intact. A review of the wound care consult note dated 11/24/25, which indicated the resident had a right lower leg wound (skin tear), full thickness, with moderate drainage, and required treatment including cleansing with normal saline, application of collagen powder, and covering with bordered foam dressing, to be completed three times weekly and as needed (PRN). A review of the eTAR for November 2025 revealed that from 11/25/25 through 11/30/25 (six consecutive days), there were no nurse signatures documenting completion of ordered wound care treatment for the right lower leg skin tear. The PO, initiated 11/25/25, included: cleanse with normal saline, apply collagen powder, and cover with bordered gauze daily and PRN for wound care. A review of the CP, which included wound care interventions during this time period. On 4/6/26 at 11:24 AM, S #2 interviewed the DON who stated the DON was not present at the time of the incident and would review the record to determine if the missing documentation had been addressed. On 4/6/26 at 12:10 PM, the DON stated there was no documentation to support that the ordered wound care treatment was completed during the six consecutive days. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Wound Care Treatment Policy, dated 5/1/25, indicated that wound care treatments were to be completed as ordered and documented on the Treatment Administration Record to ensure continuity of care and promote healing . No additional information was received from the DON. NJAC 8:39-27.1 (a)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. COMPLAINT NJ#381557REPEAT DEFICIENCYBased on observation, interview, and record review, it was determined that the facility failed to ensure the safe and appetizing temperatures of food were appropriately served to the residents. This deficient practice was identified for 5 of 18 residents residing on 3 of 4 Nursing Units, including during the 4/7/26 Resident Council group meeting, and confirmed during the lunchtime meal service on 4/6/26 on a test tray tested for food temperatures (common room).This deficient practice was evidenced by the following:On 4/6/26 at 11:25 AM, Surveyor #1 (S #1) observed the meal prep, tray line in the main kitchen, in the presence of the Food Service Director (FSD) and the Regional [NAME] President of Dietary Operations (RVPDO) for food temperatures. The FSD calibrated the thermometer in ice to 41 degrees Fahrenheit (F), and she stated that it should be 41 degrees F. S #1 asked what the regulation was, and the RVPDO responded that the thermometer in ice should be calibrated to 0 degrees F. The RVPDO then stepped away and came back with another thermometer and stated that the calibration should be 32 degrees F. The surveyor requested for a test tray to be on the first cart (common room) and prepared last so that food temperature (temp) could be checked.On 4/6/26 at 11:53 AM, S #1 in the presence of the FSD followed the 1st tray cart delivered to residents in the common area. On 4/6/26 at 12:06 PM, S #1 observed all the trays passed to all the residents in the common room (13 minutes). S #1 conducted a temp test on the last test tray on the 1st cart and found the following: Regular Tray:-meatloaf 128 degrees F-vegetables 104 degrees FThe RVPDO confirmed the temperatures taken by the FSD, and stated, the temperatures were off, and the food should be hotter than that. He then stated that they were trying to figure out with the nursing department the best way to deliver the meal trays so that they hold hot.On 4/7/26 at 9:19 AM, S #1 reviewed the grievances from 1/2025-3/2026, which revealed an anonymous grievance dated 1/8/25 regarding a meal was cold and was reported to the Administrator and resolved by temp taken at start of meal tray line and audits were done randomly. A grievance by an unknown resident dated 9/25/25, with complaint of cold food and the resolution was extra plate warmers were ordered and to have available staff during meals to pass trays out timely. On 4/7/26 at 9:19 AM, Surveyor #2 (S #2) reviewed the previous three months of Resident Council Minutes which revealed on 1/7/26, prior concerns were dietary with meal trays, food arriving cold.On 4/7/26 at 10:00 AM, S #2 conducted Resident Council Meeting with five unsampled residents who were alert and oriented (Residents # 30, #44, #50, #56, and #66) chosen by the facility to attend. 4 of 5 residents stated food was still arriving cold and one stated food was lukewarm and not hot; for breakfast, the food was always cold and had not improved; other meals if they ate in their rooms were cold; coffee was ice cold, oatmeal cold; 5 out of 5 residents stated they observed that food sits on the units for sometimes up to forty-five minutes before it was delivered to the residents.On 4/8/26 at 10:18 AM, the survey team met with the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the temp of the food on the test tray and the residents in the Resident Council meeting stating cold breakfast and cold food.On 4/8/26 at 1:37 PM, the team met with the DON and the LNHA provided pictures of food temp taken on a test tray of pureed foods in the Unit 4 lunch meal; provided temp logs of a meal prep tray line for February and March 2026. S #1 notified the LNHA that the out of compliance test tray was observed and confirmed when temp were taken in the common room area. No additional information was provided by the LNHA. A review of the undated facility's Food Preparation and Service Policy revealed under Policy Interpretation and Implementation #1, Danger Zone means temp.below 135 degrees F that allow the rapid growth of pathogenic microorganisms that cause foodborne illness . Under Food Preparation, Cooking and Holding Time/Temperatures #5 revealed, Food thermometers used to check food temperatures are . calibrated for accuracy .NJAC 8:39-4.1,17.4(a)2