

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2025
NAME OF PROVIDER OR SUPPLIER Careone at Parsippany		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Mazdabrook Road Parsippany Troy Hill, NJ 07054	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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

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

TITLE

(X6) DATE

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Complaint #409367Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice and the facility's policies and procedures for 1 of 2 residents, Resident #1, reviewed for wound care. 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.On 11/7/25 at 10:30 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #1. The admission Record (a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, type 2 diabetes mellitus, peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), hypertension (high blood pressure), heart failure, difficulty walking, and generalized muscle weakness.A quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 10/11/24, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #1 scored a 15 out of 15, which indicated the resident was cognitively intact. In Section M (Skin Conditions) of the MDS, Resident #1 was coded as having diabetic foot ulcer(s). A nurse progress note by Licensed Practical Nurse (LPN) #1, dated 9/28/24, indicated the resident's left heel during wound care was noted with a foul odor and dark colored tissue inside the wound bed. LPN #1 documented she informed the Assistant Director of Nursing (ADON) and the primary physician. The resident was to be seen by the Wound Care Consultant (WCC) on Monday (9/30/24). A WCC note dated 9/30/24 revealed the resident was being treated for a left plantar heel diabetic ulcer and a right, medial, plantar heel diabetic ulcer. The wounds were both classified as chronic. The left plantar heel ulcer was assessed as being 6 centimeter (cm) x 10 cm x 0.3 cm in size with no odor and sero-sanguineous drainage (wound fluid that is a mixture of blood and a clear, yellowish fluid called serum) and noted as improving. The resident's right heel ulcer was assessed as being 4 cm x 3 cm x 0 cm in size with no odor or drainage. The WCC made additional recommendations to consult with the primary physician to consider antibiotics and a bone scan. A WCC note dated 10/7/24 revealed the resident was being treated for a left plantar heel diabetic ulcer and a right, medial, plantar heel diabetic ulcer. The left plantar heel ulcer was assessed as being 6 cm x 10 cm x 0.3 cm in size with no odor and sero-sanguineous drainage; and noted with no change. The resident's right heel ulcer was assessed as being 4 cm x 3 cm x 0 cm in size with no odor or drainage; and noted with no change. The WCC made additional recommendations to consult with the primary physician to consider antibiotics and a bone scan. There was no follow up note to indicate communication with the primary physician regarding the WCC's additional recommendations. A nurse progress note by LPN #1 dated 10/8/24 documented that during wound care the resident's wound [unspecified location] had worsened with dark color inside wound and odor. LPN #1 indicated the ADON was made aware and would reach out to wound care for orders. There was no follow up note to indicate communication with the primary physician or the WCC at this time regarding the resident's wound status. A WCC note dated 10/14/24 revealed the resident was being treated for a left plantar heel diabetic ulcer and a right, medial, plantar heel diabetic ulcer. The left plantar heel ulcer was assessed as being 6 cm x 10 cm x 0 cm in size with no odor and no drainage. The resident's right heel ulcer was assessed as being 0.5 cm x 0.5 cm x 0.1 cm in size with no odor or drainage. Both wounds were noted as improving. The WCC made additional recommendations to consult with the primary physician to consider antibiotics and a bone scan. There was no follow up note to indicate communication with the primary physician regarding the WCC's additional recommendations. A WCC note dated 10/21/24 revealed the resident's left plantar heel ulcer had a measurement of 8 cm x 10 cm x 0 cm in</p>		