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	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44605 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 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 acute hospital. The surveyor reviewed the nursing/clinical progress note dated 6/13/24, documented that Resident #61 Resident discharged home today. 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 Pneumonitis, Lyme disease, Chronic Obstructive Pulmonary Disease, and Type 2 Diabetes Mellitus. Review of Resident #61's Discharge MDS dated [DATE] under Section A revealed that section A2105 Discharge Status documented, 04. Short-Term General Hospital. On 8/9/24 at 9:15 AM, the surveyor interviewed the Registered Nurse/MDS Coordinator (RN/MDS) who was responsible of completing the MDS's. The RN/MDS stated, The resident was discharged home from the facility. I made a mistake and miscoded that resident. (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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 Licensed Nursing Home Administrator (LNHA) 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), LNHA, and Director of Nursing (DON) regarding the above concern. The RCN#1 stated all MDS assessments must be filled out correctly. The 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, LHNA and DON. There were no further information was provided. NJAC 8:39-11.1, 11.2(e)(1)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37175 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 stage 2 pressure ulcer (PU) (an open wound that affects both the top and bottom layers of the skin but has not yet reached the fatty tissue). 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 [DATE] with diagnoses that included but were not limited to Nontraumatic Intracerebral Hemorrhage (bleeding inside the skull), Acute Respiratory Failure, and Dysphagia (difficulty swallowing). Resident #62 was discharged to the hospital on 07/07/23. A Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate management of care, dated 07/06/23 under section C0700, C0800, C1000, revealed that the resident had severely impaired decision-making skills, with short and long-term memory problems. Further review of the MDS under section M revealed that Resident #62 had one (1) stage 2 PU that was present on admission. A review of the admission nursing assessment dated [DATE] under section H revealed Resident #62 had a sacral stage 2 PU measuring 3.0 cm. x 2.0 cm. x 0.1 cm. A review of Resident #62's interdisciplinary person-centered comprehensive CP did not identify that the resident had a PU present on admission. On 08/13/24 at 09:50 AM, the surveyor interviewed the Director of Nursing (DON), who acknowledged that the CP did not address the pressure ulcer 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. NJAC 8:39-11.2 (d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 44605 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 NPO (nothing by mouth); b.) document the colostomy care performed; and c.) document an assessment on a resident who was transferred to the hospital for a scheduled surgical procedure. 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 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 by mouth. 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: Dysphagia following Cerebral Infarction, Metabolic Encephalopathy, Muscle Weakness, and Type 2 Diabetes Mellitus. A review of Resident #22's Minimum Data Set (MDS), an assessment tool used for the management of care, dated 7/8/24, documented the resident had a Brief Interview for Mental Status (BIMS) and score of 9 out of 15, indicating that Resident #22 had moderately impaired cognition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the August 2024 Order Summary Report (OSR) included a PO dated 6/27/24 for, NPO diet, NPO texture, for PEG-Tube feeding. (a medical device used to provide nutrition, hydration and medications directly into the stomach). Further review of the August 2024 OSR revealed the following PO: 1. Acetaminophen Tablet 325 MG, give 2 tablets by mouth every 6 hours as needed for Mild Pain (Pain Score 1-4), dated 6/27/24; 2. Milk of Magnesia Suspension 400 MG/5ML (Magnesium Hydroxide). Give 30 ml by mouth every 24 hours as needed for no bowel movement for 3 days, dated 6/27/24; 3. Losartan Potassium Tablet 25 MG, give 1 tablet by mouth one time a day for HTN, dated 6/28/24. 4. Sertraline HCl Tablet 100 MG, give 1 tablet by mouth one time a day for depression, dated 6/28/24; 5.Loperamide HCl Capsule 2 MG, give 1 capsule by mouth every 8 hours as needed for Diarrhea, dated 7/30/24. 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 PEG-tube route. All the other medications of Resident #22 were administered via PEG tube route. On 8/9/24 at 11:45 AM, the Licensed Nursing Home Administrator (LNHA) 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 LNHA, Director of Nursing (DON), and Regional Clinical Nurse (RCN#2). The RCN stated acknowledged that the medication route was incorrect for Resident #22 who was NPO. No further information was provided. 37791 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 Hyperlipidemia (a condition in which there are high levels of fat particles (lipids) in the blood), Hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone) Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures) and Hypertension (a condition in which the force of the blood against the artery walls is too high). A review of the Admission MDS, an assessment tool used to facilitate the management of care, dated 5/20/23, reflected that Resident #64 had a BIMS score of 4 out of 15, indicating a severe impaired cognition. A review of the facility Progress Notes (PN) revealed a Physician/Practitioner Progress Note dated 9/18/23 at 13:40 (1:40 PM) documented the following: Patient is scheduled for surgical debridement of the right leg on Friday, September 22. Patient needs to arrive at hospital [name redacted] by 11:00 AM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A further review of the resident's medical records revealed no written PN or nursing assessment on the morning of 9/22/23 that would indicate the resident was admitted to the hospital for a surgical procedure. 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 surgical procedure. The PN revealed a PO administration note from the facility nurse dated 9/22/23 at 19:47 (7:47 PM) which revealed the following: out for surg (surgery). 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 scheduled procedure, a nursing staff will review the resident's medical records and if they identify anything that could 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 LNHA, DON, and RCN#2. The DON 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 surgical procedure. 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 attention to Colostomy (main purpose is to manage and care for a colostomy), Cognitive Communication Deficit (difficulties with communication that are caused by disruptions to cognition) and Dementia (a group of thinking and social symptoms that interferes with daily functioning). A review of the Admission MDS, an assessment tool used to facilitate the management of care, dated 05/10/24, reflected that Resident #262 had a BIMS score of 15 out of 15, indicating that the resident was cognitively intact. A review of the OSR revealed the following PO: A PO dated 9/28/23, for Colostomy care every shift. A PO dated 9/28/23, for Colostomy output every shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the October 2023, electronic Treatment Administration Record (eTAR) and the October 2023 electronic Medication Administration Record (eMAR) did not indicate a PO for Colostomy care every shift and no PO for Colostomy output every shift. There were no documentation in the hybrid medical record which reflected that both Colostomy care or Colostomy output were documented every shift. A review of Resident #262's Comprehensive Care Plan dated 9/29/23, for Colostomy care which revealed the following interventions/tasks: -Change ostomy appliances as needed, dated 9/29/23. -Irrigate colostomy per physician's orders dated 9/29/23. -Record bowel movements and report abnormalities dated 9/29/23. On 8/9/24 at 8:30 AM, the surveyor interviewed LPN #1 regarding the process of documenting the colostomy care in the medical record. LPN #1 stated that a physician would write a PO for colostomy care and the nurses will document this in the eTAR. LPN #1 further stated that only the nurses can document colostomy care. LPN #1 added that changing a colostomy bag, documenting colostomy output, and assessing the colostomy stoma area (opening in your belly's wall that a surgeon makes for waste to leave your body if you can't have a bowel movement through your rectum) must be documented every shift in the eTAR. LPN #1 stated that assessing the stoma site around the colostomy is a separate assessment from the weekly skin assessments since nurses must assess the colostomy every shift. On 8/9/24 at 8:45 AM, the surveyor interviewed the Registered Nurse (RN) who stated to the surveyor that colostomy care must be documented in the resident's medical record and only the nurses could document. The RN 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 LNHA, DON, and RCN#2. Both the DON and RCN#2 acknowledged that nurses should have documented the colostomy 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 DON 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 DON included the following: 4. The following information is to be documented in the resident medical record: a. Objective observations. b. Medications administered. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 37175 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure a resident on hemodialysis (artificial means of removing waste from nonfunctioning kidneys) was consistently assessed, documented, and monitored after hemodialysis treatments. This deficient practice was identified for 1 of 1 resident's (Resident #10) reviewed for dialysis and was evidenced by the following: On 08/06/24 at 10:56 AM, the surveyor was touring the first-floor unit, and Resident #10 was not in their room and was informed that the resident was out at hemodialysis. On 08/07/24 at 11:15 AM, the surveyor observed 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 End Stage Renal Disease (kidney failure), Diabetes (too much sugar in the blood), and Dementia (a group of symptoms that affects memory, thinking and social abilities). A review of the Order Summary Report under special instructions revealed the resident goes to dialysis every Tuesday, Thursday, and Saturday. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate resident care, dated 05/23/24, revealed a Brief Interview from Mental Status (BIMS) of 13 out of 15, which indicated the resident's cognition was intact. The MDS also indicated the resident received hemodialysis. A review of the resident-centered care plan included but was not limited to a focus area that the resident had Renal insufficiency related to Chronic Renal Disease and received hemodialysis on Tuesday, Thursday, and Saturday with interventions that included, confer with a physician and or dialysis treatment center regarding changes in medication administration time/dosage pre-dialysis as needed and coordinate dialysis care with the dialysis treatment center. A review of the form titled, Dialysis Center Communication Record for Resident #10 revealed the first section to be filled out by the facility nurse which included the resident's name, treatment date if the resident is receiving antibiotics, pain medication, had any emesis, diarrhea, or had fallen in the last 48 hours. An area was to be filled out for the resident's vital signs, including temperature, pulse, respirations, blood pressure, graft site, catheter site, and nurse signature-the following section was to be filled out by the Dialysis center nurse communication back to the center. The areas included the dialysis start and end time, the pre and post-weight, laboratory results, catheter size, treatment problems, medication administered, bowel movements, and the signature of the dialysis nurse. The last section, to be completed by skilled nursing facility nurse post-treatment, asked for information including blood pressure, temperature, pulse, bleeding at the access site, bruit, thrill palpated, receiving nurse signature, and date. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Hemodialysis Communication binder, which started in May 2024 and documented the following: May 2024 included eight forms, and 6 out of 8 had incomplete post-treatment filled out. Further review revealed five forms dated 05/09/24 through 05/18/24 did not include the last section for the post dialysis treatment documentation. June 2024 included 13 forms in which 7 out of 13 forms had incomplete post dialysis treatment filled out. July 2024 included 13 forms in which 11 out of 13 forms had incomplete post dialysis treatment filled out. August 2024 included three forms in which 2 of the 3 forms had incomplete post dialysis treatment filled out. On 08/07/24 at 12:30 PM, the surveyor interviewed the Registered Nurse Supervisor (RN/S), 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 Director of Nursing (DON), who stated that the nursing staff should be documenting on the sheets. On 08/13/24 at 11:03 AM, the surveyor interviewed the DON, who stated that the post-dialysis assessment was not completed on the communication sheet and acknowledged that it should have been filled out. The DON further stated that the forms for 05/09/24 through 05/18/24 were filled out but the nurses used the old forms which did not have the post dialysis treatment section area for documentation. The DON 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. NJAC 8:39-27.1(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44605 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 Director of Culinary Service (DCS). 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 Licensed Nursing Home Administrator (LNHA) 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 LNHA, Director of Nursing (DON), and Regional Clinical Nurse (RCN#2). The surveyor reviewed the kitchen concerns. No further information was provided. NJAC 8:39-17.2(g)