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	12/19/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review it was determined that the facility failed to maintain the dignity of 2 unsampled residents during the lunchtime meal in the 2 of 3 dining rooms observed. The deficient practice was evidenced by the following. 1.The surveyor observed the lunchtime meal in unit 2 dining room on 12/15/25 at 12:44 PM, there were seven residents and Certified Nursing Aide #1 (CNA #1). CNA #1 at that time was standing while feeding Resident #44 (unsampled resident) with use of a weighted spoon. The resident had three compartment dish plate. On that same date, the surveyor went to the nursing station just across the dining room, to find a nurse, and the Registered Nurse/Unit Manager (RN/UM) was at the phone at that time. The Unit Clerk (UC) then assisted the surveyor, both the surveyor and the UC went back to the dining room and both observed CNA #1 still standing while feeding Resident #44. Outside the dining room, both the UC and the surveyor observed CNA #1 standing and continued to feed the resident. The UC acknowledged that CNA #1 was standing while feeding the resident. On 12/15/25 at 12:47 PM, the surveyor interviewed the Registered Nurse (RN), who informed the surveyor that she was a nurse for unit 2, and the surveyor notified the above observation and concerns with CNA #1. Both the surveyor and the RN went to the dining room and observed CNA #1 still standing and feeding Resident #44. The RN then waived to CNA #1 and used hand gestures to tell CNA #1 to sit down, and that was the time CNA #1 sat down. Afterward, the surveyor in the presence of the RN, notified the RN/UM of the above findings and concern. The RN/UM and the RN had no answer as to why staff should not be standing while feeding a resident. Then, the Director of Nursing (DON) came and was notified of the above concern and confirmed that the staff should not be standing while feeding. A review of Resident #44's care plan (CP) revealed that the resident was not care planned for staff to stand while feeding the resident nor the resident's preference was for the staff to stand while feeding. Further review of the medical records revealed there were no documented evidence that the staff should stand while feeding the resident as resident's preference. 2.On 12/17/25 at 12:19 PM, the surveyor observed unit 1 dining area for lunch, there were 15 residents with four staff feeding residents, and the Recreation Staff (RS) (was not feeding) assisting other residents. The surveyor also observed that one table where the RS was assisting other residents, 3 of 4 residents were eating, and one was not eating (Resident #115). There was another table with two lunch trays, one of the tray was used and another tray was untouched and covered. On that same date and time, the surveyor observed Resident #39, who was seated in a Geri chair (often referred to as a medical recliner, blends the advantages of recliners and wheelchairs) with side table and had no meal tray. Resident #39 was seated facing all residents who were eating their lunch except Resident #39 and Resident #115. At that same time, the surveyor asked the RS if Residents #115 and #39 were served with lunch and as to why they did not have a meal tray in front of them. The RS informed the surveyor that all residents inside the dining area received and started to eat at around 12:00 PM, except for Resident #39, because they were waiting for the nurse to feed the resident. She also stated that Resident #115 had received lunch tray and was finished eating. She also confirmed that the two trays on the side on top of the table were for Residents #39 and #115. At 12:23 PM, after surveyor's inquiry, the Licensed Practical Nurse (LPN) (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	came and took the lunch meal on the table where the other used tray was, and placed on top of the side table near Resident #39. The LPN left the dining room without feeding the resident. At 12:25 PM, CNA #2 started to feed Resident #39. A review of the provided Meal Delivery Times, that was provided by the Licensed Nursing Home Administrator (LNHA), included that the dining room service during lunch was at 12:15 PM. It also included information that the scheduled times may vary by +/- (plus or minus) 10 minutes. On 12/17/25 at 12:50 PM, the surveyor asked the LNHA for copy of dining services and resident rights policies. On 12/17/25 at 1:18 PM, the surveyor notified the DON of the above findings and concern with dining observation in units 1 and 2. The surveyor asked the DON if it was appropriate for the resident to wait to be fed when everyone was eating, and what the expectation was. The DON stated that it was not appropriate, everybody should be eating at the same time. The DON acknowledged that it was an expectation that it was resident's rights to be respected including the right to be served meals at the same time. On 12/18/25 at 12:11 PM, the survey team met with the LNHA and DON, and the surveyor notified them of the above findings and concerns. On 12/19/25 at 11:42 AM, the survey team met with the LNHA, the DON, and the LNHA stated that both residents identified during dining observation both required behavior to be managed prior to start feeding. A review of the facility's Resident Rights Policy that was provided by the LNHA, edited 5/30/24, revealed, that employees shall treat all residents with kindness, respect, and dignity. A review of the facility's Dining Room Audits Policy that was provided by the LNHA, with a revision date of October 2017, revealed, that the facility audits the food and nutrition services department regularly to ensure that resident needs are met, and that dining is safe and pleasant experience for residents. Policy Interpretation and Implementation: 2. The auditor will assess: d. whether residents at each table are served together; . On 12/19/25 at 12:48 PM, the survey team met with the LNHA, DON, and the Clinical Support Coordinator for an exit conference, and there was no additional information provided by the LNHA. N.J.A.C. 8:39-4.1(a)(5,12,28), 27.1(a)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure 1 of 18 resident's (Resident #9) call bell was within reach and able to use to accommodate the residents' needs. This deficient practice was evidenced by the following:On 12/15/25 at 11:20 AM, while conducting the initial tour of the facility, the surveyor observed Resident #9 in their room, and in bed. The surveyor also observed the call bell was on the floor, not on the bed, and not within the reach of the resident if needed to use. The surveyor then asked the resident if they used the call bell if they needed help and if the staff came to help, and the resident shrug their shoulders. At this time, a Certified Nurses Aide (CNA), came into the room and notices the surveyor looking for the call bell device. The CNA then placed the call bell device on the bed next to the resident, after surveyor's observation. The surveyor reviewed the electronic medical record (eMR) of Resident #9, which revealed the following: A review of the admission Record (an admission summary) reflected that the resident had diagnoses of but not limited to; malignant neoplasm of the brain (brain cancer), essential hypertension (high blood pressure), and generalized muscle weakness. A review of Resident #9's Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 11/20/25, reflected that the resident had a brief interview for mental status (BIMS) score of 99, which indicated the resident was unable to complete the interview. A review of the comprehensive Care Plan (CP) dated 11/11/25, revealed a focus that the resident was at risk for falls and an intervention to reinforce the need to call for assistance.On 12/18/25 at 12:20 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified the LNHA and DON of the observation of Resident #9's call bell not within the resident's reach. On 12/19/25 at 11:42 AM the survey team met with the LNHA and DON, and the LNHA stated in response to the call bell concern that the call bell was only temporarily hanging off the bed, it was corrected immediately, and the resident could call for help otherwise.On 12/19/25 at 12:21 PM, the survey team met with the LNHA and DON, and the LNHA stated that the call bell device was not within reach of the resident at the time of the surveyor's observation.On 12/19/25 at 12:49 PM, the survey team met with the LNHA, DON and Clinical Service Coordinator (CSC) for an exit conference. The LNHA and DON did not provide any further pertinent information.A review of the facility's Answering the Call Light Policy, dated 9/2022, the policy reflected, under General Guidelines, line 5, ensure that the call light is accessible to the resident when in bed.NJAC 8:39-31.8 (c)(9)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and review of other facility documentation, it was determined that the facility failed to thoroughly complete in writing the issued required beneficiary notice for 2 of 2 residents reviewed for Beneficiary Protection Notification, (Residents #7 and #44). This deficient practice was evidenced by the following:1.On 12/17/25 at 9:45 AM, the surveyor reviewed the provided Skilled Nursing Facility (SNF) Beneficiary Protection Notification (SNFBPN) Review completed by the facility for Resident #44, and revealed: -The SNFBPN Review indicated Resident #44 last covered Medicare A day was 12/3/25, and Resident #44 remained in the facility. The SNFBPN Review further revealed that a Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNFABN) form with blanks (no information provided) for the following information to be filled out in the form:=care(s) area that no longer occurring daily (to determine why the services were to stop for Medicare A coverage),=the estimate cost in dollar amount per day per item or service,=the options to check to determine what the resident or resident representative (RR) decided to proceed after ending the coverage for Medicare A. A review of the MDS (minimum data set) of Resident #44, revealed end of PPS (Prospective Payment System), the assessment reference date (ARD) was 12/3/25. The term end of PPS referred to the assessment period that occurred at the conclusion of a resident's Medicare Part A stay. 2.On 12/17/25 at 10:20 AM, the surveyor reviewed the provided SNFBPN Review completed by the facility for Resident #7, and revealed: -The SNFBPN Review indicated Resident #7 last covered Medicare A day was 5/31/25, and Resident #7 remained in the facility. The SNFBPN Review further revealed that a SNFABN form with blanks for the following information to be filled out in the form:=the estimate cost in dollar amount per day per item or service with handwritten information Medicaid rate, instead of the dollar amount=the options to check to determine what the resident or resident representative (RR) decided to proceed after ending the coverage for Medicare A. Further review of the above SNFABN revealed that there was no documented evidence in the residents' medical records as to why the information were blanks, to include a written information about the reason for ending the Medicare Part A (for Resident #44), dollar amount that the resident or RR would incur if they decided to continue with the services, and the resident or RR's decision were provided to had an option (option box were left blank). A review of the MDS of Resident #7, revealed end of PPS, the ARD was 5/31/25. On 12/17/25 at 10:28 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of admission (DA) the above findings and concerns with regard to required beneficiary notices of Residents #7 and #44. On 12/17/25 at 11:23 AM, the surveyor interviewed the Licensed Practical Nurse Clinical Reimbursement Coordinator (LPNCRC) in the presence of the Registered Nurse MDS Coordinator (RNMDSC). The LPNCRC informed the surveyor that she covered for the Social Worker to notify the resident or RR of the required beneficiary notice. She further stated that it was the responsibility of the social services department the beneficiary notices given to the resident and RR. On that same date and time, the LPNCRC acknowledged that the SNFABN form should be thoroughly filled out. She further stated that she was unsure if the dollar amount should be in the form or the word Medicaid rate was enough. She also acknowledged that the Medicaid rate changes. The surveyor then notified of the above findings and concerns, the LPNCRC had no response as to why there were blanks in the form. On 12/17/25 at 11:33 AM, the surveyor interviewed the Director of Social Worker (DSW), who informed the surveyor that she was responsible for sending and providing the resident or the RR of the beneficiary notices for NOMNC (Notice of Medicare Non Coverage) and SNFABN. She stated that she was unaware of the rates in the facility, and that rates at the facility changes for private pay. The DSW was also unaware of the Medicaid and other insurances rates. The DSW had no response when asked by the surveyor how she was able to relay the Medicaid and other facility's rates in the SNFABN when communicating to the resident or RR when providing the beneficiary notices. At that same time, the surveyor notified of the above findings and concerns with the beneficiary notices of Residents #7 and #44. The DSW (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed that she did not speak with the RR and just left a message in their phone and did not receive an email and electronic signature as well confirming of the receipt and acknowledgment of beneficiary notices. She did not have an answer as to why there were blanks in the forms. She also stated that there was no way they can input the money or actual dollar amount in the form that was why she handwritten the Medicaid rate in the SNFABN. On 12/17/25 at 11:43 AM, the surveyor interviewed the Business Office Manager (BOM), who informed the surveyor that private pay rate was $675, Medicaid had a fixed rate a day that changes once a year, and it was from a state letter that they receive annually. The surveyor asked for a copy of the most recent letter. She also stated that the Medicare rates differs and depends on each resident's MDS RUG (Resource Utilization Groups (RUG), which are components of the Nursing Home Reform Act. The MDS is a standardized assessment tool used to evaluate residents' needs and guide individualized care plans), once the resident transitioned back to Medicaid or became LTC (Long Term Care) with pending Medicaid they get the rate of Medicaid, and private pay rate may change. On that same date and time, the surveyor asked the BOM if it was an expectation that the dollar amount in the SNFABN form had a specific dollar rate if the above information of rates changes and depends on the resident's insurance, and the BOM had no response. On 12/18/25 at 12:11 PM, the survey team met with the LNHA and Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. On 12/19/25 at 11:42 AM, the survey team met with the LNHA, the DON, and the LNHA stated that the facility acknowledged not filling up the form completely including adding the rate. He further stated that both residents were admitted under Medicare, the RR decided to transition to Medicaid. The surveyor then asked the LNHA if the transition for the new billing rate was completed or fulfilled according to the regulation, and the LNLHA stated not. A review of the facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notices Policy that was provided by the LNHA, with a revision date of September 2024, revealed, under policy statement, a resident is informed in advance and in writing when Medicare payment denial or change in coverage is likely. Policy Interpretation and Implementation: .3. The resident/beneficiary receiving the notice must: a. be able to read, understand, act on his/her rights, and comprehend the notice; .4. Written notices are provided in person to the beneficiary when possible. A copy of the notice is provided to the beneficiary immediately after the notice is signed. Skilled Nursing Facility Advance Beneficiary Notice: 1. The facility will issue SNFABN to any Medicare resident prior to providing care that Medicare usually covers, but m ay not pay for under the current circumstance because the care is not medically necessary or considered custodial. 2. The SNFABN provides information to the resident so that he or she can decide whether to get the care that may not be paid for by Medicare and assume financial responsibility . On 12/19/25 at 12:48 PM, the survey team met with the LNHA, DON, and the Clinical Support Coordinator for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-4.1(a)(8); 5.1(a)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Complaint NJ #409369Based on interview and record review, it was determined the facility failed to; a.) ensure that the acute transfer must be documented in the resident's medical record and appropriate information was communicated to resident or resident representative (RR) including the reserve payment for 1 of 2 residents (Resident #106) reviewed and b.) ensure the discharge summary must include accurate information of the resident and was acknowledged by the RR to ensure safety and orderly discharge for 1 of 1 resident (Resident #110) reviewed.The deficient practice was evidenced by the following: 1.On 12/16/25 at 9:43 AM, Surveyor #1 (S #1) reviewed the hybrid medical records (combination of electronic and paper medical records) of Resident #106, and revealed: A review of the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 9/9/24 and 11/28/25, reflected that the resident had an unplanned transfer to acute hospital. A review of the electronic medical record, under forms, there were two Notice of Transfer to Acute Care Facility (NTACF), form date 9/9/24, that was created and locked (completed) on 3/31/25, and form date 11/29/25, that was created and locked on 12/1/25. Both NTACF forms were created and revised by the Director of Nursing (DON). The two NTACF's did not include information about the RR, including contact information, to whom the notices were provided and there were no documentation about the reserve payment. Further review of the hybrid medical records revealed, there was no documented evidence that the facility included documentation and information conveyed to the RR about notice of bed hold policy and the reserve payment. On 12/16/25 at 11:30 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON informed S #1 that it was the DON's responsibility to notify the resident or RR of the notice of transfer to acute care or hospital including the bed hold notice, and it was the Director of admission (DA) responsibility upon admission for bed hold notice. On 12/16/25 at 11:33 AM, S #1 interviewed the DA, who informed S #1 that as part of facility's process, she was responsible for obtaining the resident or RR's signature in the admission packet that contained the rate that facility bill the resident upon admission. She also stated that she would provide a copy of the resident's admission packet. On 12/16/25 at 11:47 AM, S #1 asked the DON to review the paper closed records that was provided to S #1. The DON confirmed that there should be a reserve payment information in the NTACF for 9/9/24 and 11/28/25. She also stated that there was a typographical (typo) error in the 11/29/25 NATCF and that date should have been 11/28/25. On 12/18/25 at 12:11 PM, the survey team met with the LNHA and DON, and S #1 notified them of the above findings and concerns with regard to Resident #106's NATCF about RR's incomplete information, and reserve payment. On 12/19/25 at 11:42 AM, the survey team met with the LNHA, the DON, and the LNHA stated that the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility acknowledged not filling up the form completely including adding the rate. S #1 then asked the LNHA if the transition for the new billing rate was completed or fulfilled according to the regulation, and the LNHA stated not. A review of the facility's Bed-Holds and Returns Policy that was provided by the LNHA, with a revision date of October 2022, revealed under Policy Statement, residents and/or RR are informed (in writing) of the facility and state bed-hold policies. Policy Interpretation and Implementation: 1. All residents/RR are provided in written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: 1. Notice 1: well in advance of any transfer (e.g. in the admission packet); and b. Notice 2: at the time of transfer (or, if the transfer was emergency, within 24 hours). 2. Reissuance of notice 1 must occur if either the bed-hold policy under the state or facility policy changes after the notice is issued. 3. Multiple attempts to provide the RR with notice 2 should be documented in cases where staff were unable to reach and notify the RR timely. 4. The written bed-hold notices provided to the residents/RR explain in detail:.b. the reserve bed payment policy as indicated by the state plan. On 12/19/25 at 12:48 PM, the survey team met with the LNHA, DON, and the Clinical Support Coordinator (CSC) for an exit conference, and there was no additional information provided by the LNHA. 2. On 12/18/25 at 10:04 AM, Surveyor #2 (S #2) reviewed the medical records of Resident #110, and revealed: A review of the discharge (d/c) summary dated 8/23/24, revealed that the document did not contain the signature of the resident or the RR. There was no documented evidence that the resident or the RR acknowledged the d/c summary. In addition, there was no documented evidence that the facility communicated to the resident or RR the d/c summary information and instructions. Further review of the d/c summary dated 8/23/24, revealed that the vital signs (key measurements of the body's most basic functions (Temperature, Pulse, Respiration, Blood Pressure, plus often Oxygen Saturation, and Pain) that provide a snapshot of a patient's health status, help detect changes, monitor treatment effectiveness, and identify emergencies, forming a fundamental part of patient assessment from admission to ongoing care) captured were from date 8/14/24. A review of the August 2024 physician orders revealed that there was no documented evidence that the facility obtained an order for d/c. On 12/18/25 at 12:25 PM, S #2 notified the LNHA and DON of the above findings and concerns about Resident #110's d/c. On 12/19/25 at 11:43 AM, the LNHA provided documentation of vital signs taken on the morning of the d/c (8/23/24), as well as a Progress Note (PN) completed by the nurse on the day of d/c. S #2 reviewed in the presence of the survey team and the LNHA and DON the provided vital signs and PN documentation and revealed, the last documented vital signs prior to d/c were recorded at 9:47 AM of 8/23/24, while the time of d/c occurred at 7:30 PM, as noted on the Discharge Summary. At that time, the LNHA acknowledged the above findings and issues with the resident's d/c documentation and stated, The expectation is for d/c documentation to include current vital signs, a (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician's d/c order, and signatures from the resident or RR, along with documentation of safe d/c procedures. A review of the facility's Discharging the Resident Policy, included .Assess and document the resident's condition at d/c . On 12/19/25 at 12:48 PM, the survey team met with the LNHA, DON, and the CSC for an exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-4.1; 27.1(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to update and revise a comprehensive care plan to reflect the current status of the residents, a.) with regard to appropriate infection control precautions for 1 of 4 residents, (Resident #83) reviewed for infection control and b.) specifically discontinue a care plan for a resident with discontinued indwelling catheter for 1 of 2 residents (Resident #4) reviewed for urinary catheter. This deficient practice was evidenced by the following: 1. On 12/15/25 at 10:09 AM, Surveyor #1 (S #1) observed Resident #4 sitting up in bed. S #1 interviewed Resident #4, in the presence of the resident representative (RR), who stated that when they first were admitted to the facility that they had an indwelling catheter but that it was removed and that they were recently hospitalized . A review of Resident #4's admission Record or face sheet (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; multiple fractures of pelvis, multiple fractures of ribs right side, and anemia (blood disorder in which the blood has a reduced ability to carry oxygen). A review of Resident #4's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that Resident #4's cognition was intact. Further review reflected Resident #4 had an indwelling catheter. A review of Resident #4's comprehensive care plan (CP) included the following focus area: Use of indwelling urinary catheter related to [redacted] edema with interventions and had an initiated date of 9/30/25. A review of Resident #4's Order Summary Report (physician's orders) of active orders as of 12/1/25, did not include a physician's order (PO) for an indwelling catheter. A review of Resident #4's Progress Notes (PN) reflected the following note dated 10/20/25, which indicated Resident #4's indwelling catheter was removed without complication. Further review of Resident #4's PN reflected that Resident #4 was hospitalized and returned to the facility on [DATE], and did not have an indwelling catheter. On 12/16/25 at 11:56 AM, S #1 asked the Registered Nurse/Unit Manager (RN/UM who was responsible for updating CP, and she stated that the Director of Nursing (DON), Assistant Director of Nursing, Unit Managers and case manager would update the CP. On 12/16/25 at 11:58 AM, S #1 interviewed the Registered Nurse (RN) regarding Resident #4. The RN stated that the resident was admitted in September from the hospital after a motor vehicle accident and had an indwelling catheter. The RN stated that Resident #4 did not have an indwelling catheter now. The surveyor asked the RN if a resident's indwelling catheter was removed if the CP should be updated. The RN stated that she did not update CP. The RN stated that the resident had recently been sent to the hospital and came back. (continued on next page)

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	315468	A. Building B. Wing	12/19/2025

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/25 at 12:04 PM, S #1 interviewed the RN/UM regarding Resident #4's CP, and the RN/UM stated that when a resident returned from the hospital a new CP should be made. She further stated that when Resident #4 returned from the hospital, the nurse should have resolved the indwelling catheter CP. The RN/UM also stated that she was going to resolve the indwelling catheter on Resident #4's CP. On 12/18/25 at 12:14 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident # 4's indwelling catheter was removed on 10/20/25 and the resident's CP was not updated and that when the resident returned from a hospitalization in December 2025, and did not have an indwelling catheter, the resident's CP also was not updated. On 12/19/25 at 11:44 AM, in the presence of the DON, the LNHA stated that there was a failure to update the CP. The LNHA stated that care was delivered according to PO and the resident's condition at all times. The LNHA stated that education was ongoing to prevent recurrence. The LNHA stated that once the issue was identified by the surveyor, Resident #4's CP was immediately updated to accurately reflect their current status. The LNHA did not provide any additional information. 2.On 12/15/25 at 9:45 AM, Surveyor #2 (S #2) met with the LNHA and the DON during an entrance conference, and both stated that they would get back to S #2 regarding residents on TBP (transmission based precautions) who were currently on contact precautions. S #2 reviewed the medical records of Resident #83 and revealed: A review of Resident #83's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; urinary tract infection (UTI) site not specified, cognitive communication deficit, other specified cough, and neuromuscular dysfunction of bladder (commonly referred to as neurogenic bladder, occurs when nerve damage affects bladder control, leading to issues with urine storage and release) unspecified. A review of Resident #83's most recent comprehensive MDS), with an ARD of 9/28/25, reflected that the resident had a BIMS score of 11 out of 15, which indicated that Resident #66's cognition was moderately impaired. A review of Resident #83's comprehensive CP included the following focus area, infection of urinary tract: ESBL (Extended-Spectrum Beta-Lactamase) in urine indicates the presence of bacteria that produce enzymes making them resistant to many common antibiotics, often leading to difficult-to-treat UTIs) UTI, initiated on 10/13/25. The interventions included but was not limited to maintain contact isolation precautions as indicated, date initiated on 10/13/25. Further review of the CP revealed that there was no other infection control precautions except for contact isolation (contact isolation precautions are essential in healthcare settings to prevent the spread of infections through direct or indirect contact with patients or contaminated items. Some of the key points to follow for contact isolation precautions: place a contact isolation signs on the patient's room to inform others of the precautions). A review of the provided Order Listing Report, that was provided by the LNHA, for the list of residents maintained on contact isolation revealed, Resident #83 was not included on the list. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/16/25 at 12:07 PM, S #2 asked the DON to accompany S #2 to Resident #83's room. Both S #1 and DON observed from outside of resident's room one employee and one visitor talking to the resident inside the room, and there was a posted sign for EBP (enhanced barrier precaution) outside the resident's door. The DON informed S #2 that the employee was a Speech Therapist, and the visitor was a Resident's Representative (RR). At that time, S #2 asked the DON who revised and initiated CP, and she responded that it was a collaboration between nursing management that included herself. S #2 notified the DON of the above concerns that there was no EBP CP in resident's medical records and the CP that was documented was about to maintain contact isolation. The DON had no response as to why the CP was not revised to reflect the current status of the resident as both S #2 and DON observed an EBP posted sign outside resident's room. On 12/17/25 at 12:11 PM, S #2 observed Resident #83 inside their room on their phone and there was a posted sign for EBP outside the resident's door with PPE hung on the door. On 12/18/25 at 12:11 PM, the survey team met with the LNHA and DON, and S #2 notified them of the above findings and concerns with regard to Resident #83's CP that was not revised to reflect EBP. On 12/19/25 at 11:42 AM, the survey team met with the LNHA, the DON, and the LNHA and DON did not address S #2's concern with regard to Resident #83's CP. A review of the facility's Care Plans, Comprehensive Person-Centered Policy with a revised date of March 2022, included the following: Policy, a comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered CP for each resident.7. The comprehensive, person-centered CP:a. includes measurable objectives and timeframes;b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being,.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the CP:a. when there has been a significant change in the resident's condition;b. when the desired outcome is not met;c. when the resident has been readmitted to the facility from a hospital stay. On 12/19/25 at 12:48 PM, the survey team met with the LNHA, DON, and the Clinical Support Coordinator for an exit conference, and there was no additional information provided by the LNHA. N.J.A.C. 8:39-11.2(e), (f), (g), (h)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure the accurate daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 2 of 5 days of observation. This deficient practice was evidenced by the following:On 12/15/25 at 9:00 AM, the survey team entered the facility, and the surveyor observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the receptionist. The NHRCSR posted was dated 12/15/25 with a census of 85, for the [7:00 AM - 3:00 PM] day shift. On 12/15/25 at 9:41 AM, in the presence of the survey team, the License Nursing Home Administrator (LNHA) provided a copy of the alphabetical census (total number of residents) with the total census listed as 90. LNHA confirmed the total census of residents in the facility and stated, The census is 90. On 12/16/25 at 9:00 AM, the NHRCSR posted in the lobby of the facility documented the current Resident census as 90. The LNHA then provided a Daily Attendance Report for 12/16/25, with the total census listed as 94. The LNHA informed the survey team and stated, there was one bed hold, and therefore 93 residents present in the facility. On 12/16/25 at 9:40 AM, the surveyor interviewed the LNHA and stated that the Staffing Coordinator (SC) was responsible for posting the staffing report (NHRCSR) in the morning. The LNHA further stated that the SC post the projected census and then updated it when she gets in. The surveyor then asked the LNHA if the posted census and the alphabetical census list should be consistent, and the LNHA stated, It was not consistent, I understand what you are saying. On 12/16/25 at 10:09 AM, the Director of Nursing (DON) provided an updated copy of the NHRCSR for 12/16/25 with a revised census of 94. On 12/19/25 at 11:40 AM, the LNHA and DON confirmed that the posted staff census was incorrect for the two observed days. The LNHA stated that moving forward, the 11:00 PM-7:00 AM nurse will document the census on the staffing report, which will then be updated by the Admissions Director upon arrival in the morning. NJAC 8:39-41.2 (a), (b), (c), (d)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to ensure that the resident did not receive an unnecessary medication for 1 of 5 residents (Resident #113) observed on the medication pass observation. The deficient practice was evidenced by the following:On 12/16/25 at 9:24 AM, the surveyor, while conducting the medication pass (med pass) observation, observed the Registered Nurse (RN) assigned to the medication (med) cart administer medications (meds) to Resident #113. The resident told the RN that they had leg pain and that it was a level 4. At that time, the surveyor observed the RN prepare and administer acetaminophen (a med commonly used to treat pain, commonly known as Tylenol), 325 mg (milligram), 2 tablets (tabs).The surveyor concluded the med pass observation. The surveyor reviewed Resident #113's electronic medical record (EMR), which revealed an Order Summary report (OSR) and an electronic medication administration record (eMAR) each of which reflected the following physician order (PO): Acetaminophen tablet (tab) 325 mg, give 2 tabs by mouth every 6 hours as needed (PRN) for pain, do not exceed 3 grams in 24 hours. Total 650 mg. Further review of the OSR and eMAR revealed the following PO:Acetaminophen oral tab 325 mg, give 2 tabs by mouth every 6 hours PRN for moderate pain for 10 Days, dated 12/12/25.Tramadol oral tab 50 mg, give 1 tab by mouth every 12 hours PRN for moderate pain, dated 12/12/25.Tramadol tab 50 mg, give 1 tab by mouth every 12 hours PRN for severe pain, monitor for respiratory depression sedation constipation, dated 12/15/25. Further review of the Resident #113's eMR revealed an admission Record (an admission summary) which reflected that the resident was admitted to the facility with diagnoses which included but were not limited to fracture of right femur (broken bone in leg) and essential hypertension (high blood pressure). A review of the progress note (PN) by nursing, titled Resident Assessment, dated 12/12/25, reflected the resident had a BIMS (Brief Interview for Mental Status) a tool used to screen and identify cognitive condition, Score of 15, which indicated the resident was cognitively intact. The eMR did not reveal that the resident had any PO for a pain scale (a scale that differentiates pain into different levels that can be expressed as number or other quantifier). A review of the common pain scales and descriptions which revealed that the most common pain scale was a numeric scale. Numeric Rating Scale (NRS): Asks you to rate pain from 0 (no pain) to 10 (worst pain ever). 0: No pain. 1-3: Mild (annoying, barely noticeable). 4-6: Moderate (distracting, interferes with activities). 7-9: Severe (limits activities, hard to sleep/talk). 10: Unspeakable, worst possible pain. On 12/18/25 at 10:59 AM, the surveyor interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP if they review as needed med orders for proper indication and duplication. The CP stated yes, they do. On that same date and time, the surveyor reviewed the CP electronic pharmacist information consultant review (a faxed review of meds) dated 12/15/25, which reflected:9. There was a duplicate order for Tylenol PRN pain. Please clarify and update. 11. Missing indication for mild and severe pain with current PRN pain orders. Please clarify or update orders, so that all levels of pain are covered. On 12/18/25 at 12:20 PM the survey team met with Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the concern with PRN pain meds on the med pass observation. The surveyor notified the DON that the resident had an unspecific order for pain, orders for two different meds for moderate pain, and two identical med orders, one for moderate pain and one for severe pain. The surveyor asked how the staff would differentiate which to give. The DON stated that they would get back to the surveyor. On 12/19/25 at 12:26 PM, the DON stated they called the resident's physician who gave new orders that were more specific. The DON provided a copy of an order dated 7/23/24 from another resident that listed a pain scale with 4 indicating mild. The surveyor asked the DON if the acetaminophen order the RN gave at the time had no indication. The DON stated yes. The surveyor asked the DON if there was a duplicate order for moderate pain. The DON stated yes. A review of the facility's Administering Medications Policy, dated April 2019, the policy did not reflect (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anything regarding duplicate orders or sequencing of PRN orders. The LNHA did not provide any further pertinent information. N.J.A.C. 8:39- 11.2(b), 27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store medication per manufacturer specifications and standards of practice. This deficient practice was identified for 1 of 1 emergency medication kits (e-kit) on 1 of 1 medication storage areas observed in the facility. 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 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 [DATE] at 11:48 AM, the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following:The surveyor observed, on Unit 1, an e-kit located on the bottom shelf of the bookcase that also contained the resident charts. The surveyor observed an inventory sheet attached to the e-kit, which reflected a date of [DATE], for the shortest expiration date for a med contained in the e-kit. The sheet also reflected the name of the facility and the identification of the e-kit as #47. The surveyor reviewed the facility's Consultant Pharmacist (CP) report for [DATE]. The report revealed a Unit Inspection Report (UIR) dated [DATE], for Unit 1. The UIR reflected, under e-kit: Contents of each kit were in date, YES. On [DATE] at 10:59 AM, the surveyor interviewed the facility CP by telephone. The surveyor asked the CP if they did Unit Inspections in the facility, including checking the e-kit expiration. The CP stated, yes, they did check it, and if it was due to expire or expired, they would tell the facility to replace it and send it back the pharmacy. The surveyor notified the CP about the expired e-kit. The CP stated that the facility had been having difficulty getting the pharmacy to pick up expired e-kits, but it should have been taken off the unit.On [DATE] at 12:20 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified the facility of the expired e-kit.On [DATE] at 12:26 PM, the survey team met with the LNHA and DON, and the DON stated that the expired e-kit would be returned to the pharmacy today. A review of the facility's Medication Labeling and Storage Policy, dated February 2023, reflected, under 3. If the facility has.outdated.medications (meds) or biologicals, the dispensing pharmacy is contacted for.returning.these items.A review of the facility's Pharmacy Services - Role of the Consultant Pharmacist,Policy, dated [DATE], reflected, under 3. d. Determine the contents of the emergency supply of meds and monitor the. disposition of the supply. Under 5. c. regular review of the emergency med supply. 5. d. review of med storage areas at least monthly. for proper storage.and expired meds. The LNHA did not provide any further pertinent information. NJAC 8:39-29.4(d)3(e)(g)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interviews, and a review of facility documentation, it was determined that the facility failed to ensure that a facility wide assessment was reviewed and updated to identify the required services and procedures necessary to protect the health, safety, and welfare of all residents to ensure adequate facility resources to provide resident care and services, specifically a contingency plan for staffing and the mandatory staffing ratios. These failures had the potential to affect all 90 residents who currently live in the facility during the time of the survey. This deficient practice was evidenced by the following:During the entrance conference on 12/15/25 at 9:45 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and both the LNHA and DON (Director of Nursing) stated that the facility's census (the number of residents currently under the care of a specific facility) was 90 plus 1 bed hold (1 resident was in the hospital) and their licensed bed number (the number of beds the facility has to admit residents) was 118. On 12/15/25 at 11:45 AM, the LNHA provided the surveyor a 17 page FA (Facility Assessment) which included the following:Purpose: To determine what resources are necessary to care for residents competently during regular 24/7/365 operations and during emergencies to ensure that each resident maintains or attains their highest practicable physical, mental, and psychosocial well-being.Dates of assessment: 9/11/25Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies3.1 Based on the above information and programming goals, a staffing plan has been developed to meet the professional, technical and administrative needs of the center. The plan is informed by historical experience, and projected changes. The approach takes into consideration both the type of staff (licensure or other credential) and number required. SEE ATTACHMENT 1-Staffing by ShiftAttachment consisted of staffing grid based on a Census of 98 broken down by Unit 1 with a census of 48 and Unit 2 with a census of 50. It had listed CNA (Certified Nursing Aide) with a blank line after it and listed how many CNA required for each unit and each shift. The FA did not contain the required ratio of CNA to resident which was 1 CNA to 8 residents on the day shift which remains the same regardless of what the census of facility was. The FA did not contain any information regarding a contingency plan for staffing. On 12/19/25 at 9:13 AM, the surveyor asked the LNHA if the FA that was provided was complete. The LNHA stated that that there was ongoing education and the emergency plan book that was part of the FA which was not given to the surveyor but the plan was complete. The surveyor asked if the FA was complete regarding staffing. The LNHA showed the blank assignment sheet that was in the FA and stated that the sheet showed the estimated staffing required. The surveyor asked the LNHA if he was aware of the updated regulation requirement of a contingency plan in the FA. The LNHA stated that the plan was to the meet the staffing requirements of the state and in an event where we were not meeting the requirement, our contingency plan was to reach out to our agency partners, continue to hire and offer referral bonuses. He added that it was not specific in the facility assessment but that it was their general plan. On 12/19/25 at 11:35 AM the surveyor notified the LNHA the concern that the FA did not have the required contingency plan or the staffing ratios. The LNHA stated that he had a binder for FA and that it had the contingency plan in it. The LNHA provided the surveyor a binder labeled FA which included a FA that was labeled DRAFT on the first page. The FA was dated 6/9/24. This previous FA included some information about a staffing contingency plan which was not included in the updated 9/11/25 FA (the most up to date). On 12/19/25 at 12:16 PM, the surveyor asked the LNHA, in the presence of the DON, the reason why the most up to date FA, dated 9/11/25 did not contain a contingency plan that was in a previous version, dated 6/9/24, in the binder. The LNHA stated that the FA continued in the assessment because it was in the book. A review of the facility's Facility Assessment Policy with a revised date of June 2024, included Policy, a facility assessment (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is conducted annually to determine and update the capacity to meet the needs of and competently care for residents during day-to-day operations (including nights and weekends) and emergencies.Policy Interpretation and Implementation:1. Once a year, and as needed, a designated team conducts a facility-wide assessment to ensure the resources are available to meet the specific needs of residents.Facility Assessment2. The facility assessment is used to identify current or potential gaps in care or services due to misalignment or lack of appropriate resources. 3. The facility assessment is also used to help the facility plan for and respond to changes in the needs of the resident population, and the determine budget, staffing, training, equipment, and supplies needed. 4. The facility assessment is used to inform staffing decisions. a. The facility assessment is used to ensure there is enough staff with appropriate competencies and skills sets to meet the needs of the residents identified through the review of resident assessments and plans of care. (1) Staffing needs are considered for each unit and adjusted as necessary based on changes in the resident population. (2) Staffing needs are considered for each shift, including day, evening and night shifts, and adjusted as necessary based on changes in the resident population. b. The facility assessment is used to develop and maintain a direct-care staff recruitment and retention plan. c. The facility assessment is used to evaluate the facility's ability to maintain continuity of operations during an emergency, .d. The facility assessment is used to inform contingency planning for situations that do not require activation of the emergency plan but do have the potential to affect resident care (for example, the availability of direct care nursing staff or other resources needed for resident care). The LNHA did not provide any additional information. N.J.A.C. 8:39-5.1(a); 27.1

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain a complete, accurate, and readily accessible medical records for a resident's History and Physical. This deficient practice was identified for 1 of 21 residents reviewed, Resident #109.This deficient practice was evidenced by the following: The surveyor reviewed the medical records of Resident #109, and revealed that the resident was in the facility for respite care (temporary relief for family caregivers by providing short-term substitute care for a loved one). A review of the diagnoses included but not limited to anoxic brain damage not elsewhere classified and depression. \ A review of the Minimum Data Set (MDS), an assessment tool which facilitates the plan of care, with an assessment reference date of 10/8/25, revealed short term memory problem and cognitive skills for daily decision making-moderately impaired. On 12/16/25 at 10:11 AM, the License Nursing Home Administrator (LNHA) provided the closed record-paper chart for Resident #109 for review, which revealed no evidence of a physician's History and Physical (H and P). The surveyor asked the LNHA if there were any additional papers and he confirmed that there were no other records. On 12/16/25 at 10:14 AM, the surveyor reviewed the Electronic Health Records (EHR) for Resident #109, and no physician H and P found in the electronic charting. On 12/17/25 at 11:28 AM, the surveyor interviewed the Director of Nursing (DON) in the Unit 2 nursing station, regarding Resident's #109's EHR and closed records which revealed no physician H and P completed. The surveyor and the DON reviewed the electronic system under Forms and Document tabs and the DON confirmed the primary physician did not complete an H and P. The surveyor asked the DON what was the expectation regarding the physician's initial comprehensive visit on all admission regardless of payer source, and the DON replied that it was an expectation from the physicians to complete an H and P. The DON further stated that H and P's should be done for all admissions. The surveyor requested from the DON the policy on Physician Services regarding admissions. On 12/17/25 at 1:15 PM, the surveyor reviewed Resident's #109's EHR and noted under the Forms tab, the primary physician's progress notes which was created on 12/17/25, for effective date of 10/7/25, that was done after surveyor's inquiry. On 12/18/25 at 9:00 AM, the surveyor interviewed the DON, who stated that she called the physician yesterday and the physician informed her that the H and P was previously done on paper after admission but failed to put it in the resident's medical record. The DON confirmed that the PN that was created on 12/17/25 for effective date of 10/7/25 was done after surveyor's inquiry, and still in progress (not completed). There was no paper copy of the H and P given to the surveyor. On 12/18/25 at 12:12 PM, the survey team met with the LNHA and the DON, and the surveyor notified them of the above concern with regard to the resident's H and P. On 12/19/25 at 11:41 AM, the survey team met with the LNHA and the DON, and the LNHA stated The H and P was located in the medical records; I looked yesterday in all the resident's medical records and found it between files in other medical records. The LNHA further stated that the H and P should have been in the resident's medical records. The LNHA also stated that when we asked the physician about the H and P, that was when the physician opened it in (EHR system). The LNHA added that the DON oversees Medical Record Staff to ensure resident's medical records were filed correctly, and that the H and Ps were completed. On 12/19/25 at 12:17 PM, the LNHA provided the physical paper of the H and P that was found. The surveyor reviewed the physical paper which revealed, physician's H and P dated 10/5/25. The LNHA stated, it was not found until yesterday, it was found in between other files that was why it was not provided to the surveyor or accessible and should have been part of the medical records. A review of the facility's Maintenance of Hybrid Health Record Policy which revealed under Process #4, original medical records that are created and maintained on paper will be stored in accordance with state law/regulation. A review of the facility's Physician Services Policy revealed under Policy Statement, the medical care of each resident is supervised by a licensed physician. The (continued on next page)

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	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Careone at Parsippany	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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Interpretation and Implementation revealed #6. Physician progress notes are maintained in accordance with current regulations and facility policy . NJAC 8:39-35.2(d)4