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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C #:NJ00152571 Census: 65 Sample Size: 5 The facility is not in compliance with the requirements of 42 CFR part 483, SUBPART B, for Long Term Care Facilities, based on this Complaint visit.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: C #: NJ00152571 Based on interviews and record review, as well as review of pertinent facility documents on 2/22/22, it was determined that the facility failed to provide a safe environment as well as follow their own protocol on door security for 1 of 5 residents (Resident [redacted]) reviewed for [redacted] risks. Resident [redacted] exited the building (eloped) on [redacted] at 8:11 pm when the facility's main entrance door was left unlocked and unattended. At approximately 9:50 pm the staff noticed the Resident missing. [redacted] protocol was initiated. The Resident was [redacted] on	F 689	F689 Doors were immediately checked by facility staff and head count conducted. The code gray protocol was discontinued after employee located resident [redacted] and police assisted. The receptionist was immediately Suspended and remove from her duties Resident at risk for [redacted] have the potential to be affected. an audit was completed and no other resident were identified as being affected 1)Doors and roam alert/wander guard	3/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/11/2022

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.

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD** **PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 [redacted] by a staff member in the wooded area approximately 600 feet away from the Facility. This deficient practice was evidenced by the following: 1. According to the "ADMISSION RECORD (AR)" form, Resident [redacted] was admitted to the facility on [redacted], with diagnoses that included but were not limited to: [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted] showed that Resident [redacted] cognition was [redacted] and required limited assistance from staff with Activities of Daily Living (ADL). The MDS showed that the Resident had a wandering behavior and could place the Resident at significant risk of getting to a potentially dangerous place. The MDS further showed that the Resident could ambulate independently; however, would require oversight and cueing when the Resident moves to and returns from off unit locations such as but not limited to dining, activities and distant areas. The Elopement Assessment dated [redacted] showed that the Resident was identified for at risk for [redacted] due to history of [redacted] and [redacted] behavior. The Care Plan (CP), initiated on [redacted], showed that the Resident was at Risk for Elopement related to [redacted]. Goals included were: will adjust to new environment and will not leave the center unattended. Interventions included but were not limited to: check for function of the [redacted] bracelet and when exhibiting [redacted] behavior redirect to an appropriate area. The CP further showed that the Resident had	F 689	system was inspected by vendor who on same day modified antenna to the opposite site of the [redacted] door. exit doors alarms were amplified as well. 2)The Director of Nursing and designee reviewed and provided in services on policy and procedure for [redacted] which includes emergency procedure and communication, resources and placement of resident demographics and picture at the front reception and nursing units, and code Gray protocol to center staff in all departments. 3) The Director of Nursing and designee provided additional re-education to the licensed nursing staff and maintenance in regards to the process of checking security bracelet tag, the process of resetting codes, and response when alarm has sounded. 4) Director of Nursing and designee provided additional re-education to the licensed nursing staff related to the elopement evaluation form, order transcription to monitor [redacted], roam devices and CNA staff communication. 5) Business Office Manager and Administrator have completed training with reception coverage team related to the open/close process of the reception area that included a modification to the checklist to include signatures at the completion of the shift which also includes a confirmation signature from Manager on duty/ Housekeeper or Nursing Supervisor. Director of Nursing or Designee will complete a daily review of residents at risk for elopement for one week, then will	

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 "[redacted] related to [redacted]". Interventions included but were not limited to: provide assistance in locating own room and provide directional cues. The "Facility Reportable Event (FRE)" dated [redacted] and reported to the New Jersey Department of Health (NJDOH)showed an elopement incident involving Resident [redacted]. On [redacted] at approximately 9:50 pm, the Certified Nursing Assistant (CNA #1) was unable to locate Resident [redacted]. Elopement protocol was initiated. Internal and External search was done with the help of the township Police and Firemen. Family was notified. Head count and doors were checked. Receptionist Staff (RS) was suspended pending investigation. On [redacted] at approximately 12:00 pm the Resident was found cold and unresponsive. Police officers and emergency personnel were on the scene. The Resident was pronounced dead. The family and the Primary Physician were notified. Attached with the FRE the "INVESTIGATION REPORT (IR)," dated [redacted], the facility showed the following timeline but were not limited to the following: At 7:45 pm, CNA #1 assisted the Resident to the bathroom. At 7:59 pm, RS locked the courtyard and rehab door, then proceeded to the bathroom. At 8:00 pm, Resident [redacted] informed CNA #1 that he/she wanted to watch the television in the Dayroom. At 8:20 pm, RS came back to the front desk after clocking out and left the [redacted] entrance door. At 9:40 pm, CNA #1 noticed that the Resident was not in his/her room. She continued to look for the Resident but could not find the Resident. At 9:50 pm, CNA informed the nurse that she	F 689	complete 2 times weekly for one week, then weekly for 2 weeks, then twice monthly for two months. Business office Manager of Designee will review daily checklist of receptionist duties which includes the Doors checklist at Closing for 2 weeks, then 2 times weekly for 2 weeks then twice monthly for two months. Administrator or Designee will review weekly the maintenance logs related to the function of secured doors for 4 weeks then twice monthly for 2 months Outcomes of the audits will be presented monthly to the Quality assurance performance improvement committee for a period of 3 months. Changes to the plan will be implemented if needed upon review of the audits.	

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

could not locate the Resident. Elopement protocol started. Administration notified.

The IR further showed additional actions taken during the investigations: [redacted] risk reviewed, wanderguard system tested, environmental and equipment checked by on-site vendor on 2/19/22 at 12:30 pm and left at 4:00 pm. The vendor relocated the existing antenna from the ceiling height (which was approximately 12 feet high) to the left and right side of the sliding door 28 inches to the center from the floor.

The surveyor viewed the security camera (SC) with the Administration on 2/22/22 at 11:52 am. The SC showed the following:
At 8:00 pm, the RS was sitting at the [redacted] desk. There was no evidence that the RS locked the [redacted] door.
At 8:06 pm, the RS left the front desk unattended. The SC did not capture where the RS went at this time.
At 8:11 pm, Resident [redacted] walking towards the [redacted] [redacted] entrance door. The door opened and the Resident exited the building. The Resident was wearing long sleeves shirt, pants and sneakers.
At 8:12 pm, the RS returned to her front desk.
At 8:16 pm, the RS stepped out and returned back inside using the [redacted] entrance door.
At 8:20 pm, the RS pressed the button on the side of the [redacted] door to lock the door then exited the building.

Reviewed of the Treatment Administration Record (TAR) for wanderguard and daily exit door log showed that Resident [redacted] wanderguard was checked for placement/function and exit door alarms were checked on [redacted].

During an interview with the Administrator on

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

2/22/22 from 10:01 am to 12:27 pm, he confirmed what was written on the aforementioned FRE and IR. He revealed that the RS did not lock the [redacted] door between 7:45 pm to 8:00 pm. The main entrance door was locked at 8:20 pm according to the SC. In addition, the RS left the front desk area unattended. He stated that when he viewed the SC on [redacted], the Resident approached the [redacted] door and the [redacted] did not activate, and because it did not activate the [redacted] door did not go into the locked mode and no alarm sounded. The panel was visible in the SC and it did not appear to change color as it would when it detects the [redacted].

The surveyor attempted to conduct a telephone interview with the RS on 2/22/22 at 2:04 pm and 2:10 pm; however, the RS was not available.

During an interview with CNA #1 on 2/22/22 at 2:10 pm, she confirmed what was on the FRE. She stated that Resident [redacted] was ambulatory, and confused. She stated that the Resident had [redacted] behavior and would require cueing/redirection. She stated that RS would know Resident [redacted] was at risk for elopement because the Resident's picture was posted on the front desk station. She further stated that it was everyone's responsibility including the RS to redirect residents who were exit seeking.

Review of the Job Description for "Receptionist" dated 9/23/21 showed under "Safety and Sanitation...Other(s) that may become necessary/appropriate to assure that the facility is maintained in a...safe...manner..."

The facility's "Closing" procedure, undated, showed "*7:45 PM...LOCK [redacted]..."

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 ____	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		
F 837 SS=B	NJAC 8:39-31.8(b) Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: C #: NJ00152571 Based on interviews and record review as well as review of other pertinent facility documents on 2/22/22, it was determined that the facility failed to consistently implement their policy on [redacted] Seeking Systems" for 3 of 5 residents (Residents [redacted] and [redacted]), reviewed for quarterly [redacted] risk. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident [redacted] was originally admitted to the facility on [redacted], with diagnoses that included	F 837	F837 Resident [redacted] most recent [redacted] risk Evaluation was completed [redacted] and is scheduled next to be completed in the month of May this Year Resident [redacted] most recent [redacted] Risk Evaluation was completed on [redacted] and is scheduled next to be completed in the month of [redacted] this year. Resident [redacted] had an [redacted] risk Evaluation completed on [redacted] and is scheduled in the month of May this Year for the next evaluation. Resident that require a quarterly [redacted] risk Evaluation have the	3/8/22

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 6 but were not limited to: [redacted] The Minimum Data Set (MDS), an assessment tool, dated [redacted], showed that Resident [redacted] cognition was [redacted] and required limited assistance with Activities of Daily Living (ADL). The Care Plan (CP) initiated on [redacted] and revised on [redacted] showed that Resident [redacted] was an [redacted] risk due to [redacted]. Intervention included but was not limited to: [redacted] in place, check for placement and function every shift. Review of Residents [redacted] medical record (MR) showed that the "[redacted] Risk Evaluation (ERE)" was completed on [redacted] and [redacted], which showed that the Resident was at risk for [redacted] However, there was no documented evidenced of quarterly assessments were completed after [redacted] through [redacted] which was not according to their policy. 2. According to the AR, Resident [redacted] was originally admitted on [redacted], with diagnoses that included but was not limited to: [redacted] The MDS dated [redacted], showed that Resident [redacted]s cognition was [redacted] and required limited assistance with Activities of Daily Living (ADL). The CP initiated on [redacted] showed that Resident [redacted] was at risk for [redacted]. Intervention included but was not limited to: check [redacted] for placement and function. Review of Residents [redacted]s MR showed that the	F 837	potential to be affected. The center identified previously that other residents were affected. On 2/9/22 The team initiated the review of quarterly [redacted] Risk evaluations. The plan was reviewed and revised and included education that was provided by the Director of Nursing and designee related to the process of Completing the Quarterly evaluations. A Process change was implemented utilizing electronic Health records schedule feature to trigger the evaluation is coming due. Director of Nursing or Designee will complete review of resident residents coming due for a quarterly [redacted] Risk Evaluation twice monthly for 2 months, then monthly for one month. Outcomes of the audit will be presented monthly to the Quality Assurance performance Improvement Committee for a period of 3 months. Changes to the plan will be implemented if needed upon review of the audits.	

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 7	F 837		

was completed on and which showed that the Resident was at risk for . However, there was no documented evidenced of quarterly assessments were completed after through which was not according to their policy.

3. According to the AR, Resident was originally admitted on , with diagnoses that included but was not limited to: .

The MDS dated , showed that Resident 's cognition was and required extensive assistance with Activities of Daily Living (ADL).

The CP initiated on showed that Resident was at risk for . Intervention included but was not limited to: provide supervisions.

Review of Residents MR showed that the ERE was completed on which showed not at risk for and on which showed that the Resident was at risk for . However, there was no documented evidenced of quarterly assessments were completed after through which was not according to their policy.

The surveyor conducted an interview with the Nurse Supervisors (NS#1 and NS #2) on from 11:30 am to 3:05 pm. They stated that ERE must be completed by the nurses every quarter and as needed for all residents to determine potential for and appropriate interventions. They stated quarterly assessment evaluations were determined from the last date it was completed. They revealed that it was the NS responsibility to ensure that the was

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 8 completed quarterly. The Job Description titled "Nurse Supervisor" dated 2003, showed "...Assist in directing the day-to-day functions of the nursing activities in accordance with the current rules, regulations...that govern the long term care facility...Administrative Functions...Perform administrative duties such as completing...evaluations...Personnel Functions...Ensure that established policies and procedures,...are followed by all department personnel...Safety...Ensure that all nursing service personnel comply with the established departmental policies and procedures..." The Job Description titled "Director of Nursing", dated 12/2006, showed that "The Director of Nursing is responsible for the day to day coordination and oversight of all aspects of the Nursing Department ...Supervises administratively all licensed nursing staff, C.N.A.'s, staffing coordinator, medical records coordinator and all staff of his/her respective discipline...." The facility policy titled "[redacted] Seeking System" undated, showed "...Residents will be provided a safe, secure living environment...Purpose: To identify residents at risk for [redacted] seeking or elopement. To implement plans to minimize the risk of elopement and manage [redacted] behaviors. To identify potential hazards and risks to [redacted] residents in the center and outside the center. To provide training in wandering, [redacted] and risk reduction measures...To establish actions steps to take if an [redacted] occurs...All residents will be assessed by nursing for potential [redacted] on admissions, with a	F 837		

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 ______	C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 9 significant change, and quarterly thereafter..." NJAC 8:39-27.1(b)	F 837		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: ___ B. WING ___	C **02/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments C #: NJ00152571 THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C #: NJ00152571 Based on interviews, and review of pertinent facility documentation on 2/22/22, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 14 of 14 days reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight	S 560	S560 The Leadership Team has met on ongoing basis and continues to identify staffing challenges and areas of improvement for Certified Nursing Assistant needs. resident have the potential to be affected. The center has implemented significant above market rate for nurses and certified nurses assistance. Incentives include tuition reimbursement, sign-on bonus program, employee referral program, and additional training if not certified. The Center continues to conduct on going job fairs with immediate interviews, as well as walk in applicants and has the ability to expedite contingency offers at the time of interview. The center continues to supplement with agency until staff is hired and has secured multiple contracts to assist with filling open	3/3/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/11/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: PSIFQU	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED C 02/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 1 residents for the day shift. The CNAs were responsible for providing direct care to the residents. The surveyor requested staffing for the weeks of 2/6/2022 and 2/13/2022. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the following: The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: - 02/06/22 had 7 CNAs for 71 residents on the day shift, required 9 CNAs. - 02/07/22 had 6 CNAs for 71 residents on the day shift, required 9 CNAs. - 02/08/22 had 5 CNAs for 71 residents on the day shift, required 9 CNAs. - 02/09/22 had 7 CNAs for 69 residents on the day shift, required 9 CNAs. - 02/10/22 had 7 CNAs for 69 residents on the day shift, required 9 CNAs. - 02/11/22 had 7 CNAs for 66 residents on the day shift, required 9 CNAs. - 02/12/22 had 6 CNAs for 66 residents on the day shift, required 9 CNAs. - 02/13/22 had 7 CNAs for 66 residents on the day shift, required 9 CNAs. - 02/14/22 had 7 CNAs for 66 residents on the day shift, required 9 CNAs. - 02/15/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. - 02/16/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. - 02/17/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs. - 02/18/22 had 7 CNAs for 63 residents on the day shift, required 8 CNAs.	S 560	shifts. The Director of Nursing or Designee will monitor the certified nursing Aide. Staffing Ratios daily and document a weekly review of the daily staffing time 4 weeks then twice monthly for 2 months to monitor. The audits will be presented to the administrator. The DON/Designee will present the results of the audit to the quality assurance performance improvement committee for review on a monthly basis for 3 months. the Committee will review and revise the plan if needed.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	PSIFQU	A. BUILDING: ______ B. WING ______	C **02/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT PARSIPPANY	**100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 - 02/19/22 had 8 CNAs for 68 residents on the day shift, required 9 CNAs. During an interview with the Administration on 2/22/22 at 3:00 pm, they are aware of the staffing ratio.	S 560		