

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315468	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2025
NAME OF PROVIDER OR SUPPLIER  Careone at Parsippany		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Mazdabrook Road Parsippany Troy Hill, NJ 07054	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>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:</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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. 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.</p> <p>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.</p> <p>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.</p> <p>2. On 12/18/25 at 10:04 AM, Surveyor #2 (S #2) reviewed the medical records of Resident #110, and revealed:</p> <p>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.</p> <p>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.</p> <p>A review of the August 2024 physician orders revealed that there was no documented evidence that the facility obtained an order for d/c.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 physician's d/c order, and signatures from the resident or RR, along with documentation of safe d/c procedures.</p> <p>A review of the facility's Discharging the Resident Policy, included .Assess and document the resident's condition at d/c .</p> <p>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.</p> <p>NJAC 8:39-4.1; 27.1(a)</p>		