STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 31654 Based on interview, record review and review of pertinent documents it was determined that the facility failed to complete and document a thorough investigation regarding bruises of unknown origin sustained on a cognitively impaired resident. This deficient practice occurred for 1 of 1 resident (Resident #92) reviewed for abuse and was evidenced by the following: On 02/14/23 at 8:46 AM, the surveyor observed Resident #92 seated in a chair next to the bed. Resident #92 was alert but unable to answer questions asked by the surveyor. Resident #92 was confused and unable to proceed with the interview. On 02/14/23 at 8:59 AM, the surveyor observed a Certified Nurse Aide (CNA) who was assigned to Resident #92, enter the resident's room with a meal tray. Plastic utensils were observed on the resident's meal tray and the surveyor inquired to the CNA about the plastic utensil use. The CNA stated that she did not know and they don't want [him/her] to hurt [him/herself]. On 02/14/23 at 1:21 PM, the surveyor was in Resident #92's room and observed the Business Office Manager (BOM) enter the room with the lunch meal tray. The surveyor observed that plastic utensils were on Resident #92's meal tray and asked the BOM about the plastic utensils. The BOM stated she usually only passed trays to people that she knew. The BOM further stated that Resident #92 used plastic utensils and stated it was due to behavior. The surveyor reviewed the Admission Record for Resident #92 which revealed: the resident was admitted with diagnoses which included, but were not limited to: psychotic disorder with delusions due to known physiological condition, major depressive disorder, and chronic obstructive pulmonary disease. An annual Minimum Data Set (MDS), an assessment tool dated 04/26/22, revealed the resident scored 2/15 on the Brief Interview for Mental Status which indicated the resident was severely cognitively impaired. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Progress Note signed by the former Director of Nursing, Registered Nurse, Late Entry Effective Date 07/01/22, 12:52 PM, revealed Note: on 06/30/22 approximately 8:30 AM, supervisor reported that during AM (morning) care, staff noted Resident #92 to have a bluish discoloration near [his/her] eye. Immediately following report this writer proceeded to assess resident's status. Upon assessment resident was noted to have a bluish discoloration to left eyelid, circumoral in nature. Resident was able to open and close left eye without difficulty. No redness, bleeding and or signs of trauma noted to the left eye . Left eyelid slightly swollen no other visible injuries observed . Upon interview resident able to recall side rail use but unable to recollect correct timing, day of event .cold compress to left eyelid x 15 mins [minutes] . A subsequent nursing progress note documented on 07/01/22 at 2:44, Still noted with left eye purple discoloration . A nursing progress note dated 07/01/22 at 14:30, documented This am, resident's been trying to hit staff while being cared . A progress note dated 07/02/22 at 4:00, entered by a Licensed Practical Nurse (LPN) revealed recent noted ecchymotic area on L [left] eye and other areas ., Can get aggressive with changes. A progress note documented by an LPN on 07/03/22 at 7:00, revealed discoloration near L eye .confused to how it happened . A Nursing General/Health/History/Vitals documentation note dated 06/30/22 at 21:06, and signed by an LPN, revealed Describe other reason for admission/skilled care/CIC, noted ecchymotic areas on body. Resident on [blood thinner], Additional details about the note revealed: noted several areas of ecchymosis on body. No complaints of pain when asked. Slept well entire shift. Noted moderately aggressive with care. An SBAR (Situation, Background, Assessment, Recommendation) summary for providers dated 12/11/22 at 12:43, revealed a Registered Nurse documented that Resident #92 had redness on the cheek, right side. A nursing note, Signed by a Registered Nurse, Effective Date: 07/21/22 at 15:48 , revealed, resident noted throwing things to other residents and hitting staff .lots of screaming and scolding episodes in the Atrium due to lots of stimulating factors that may be contributing to [his/her] behavior . The Care Plan for Resident #92 revealed a Care Plan (CP) focus that resident was at risk for injury or complications from anticoagulation therapy medication, initiated and revised on 04/27/22. The goal was for Resident #92 not to exhibit sign/symptoms of bleeding x 90 days, with a target date of 03/08/23. Interventions included, observed for active bleeding, i.e., hematuria, bruising .created on 04/27/22. The CP focus for nutritional risk with a goal of consuming 50-100% meals and 100% supplements daily, initiated on 10/26/22, with a target date of 03/08/23. The CP for nutritional risk, included an intervention of plastic utensils on meal trays due to behavioral issue, initiated 08/02/22. The CP focus for the resident was at risk for skin breakdown due to advanced age, anticoagulation therapy, and decreased PO [by mouth] intake created on 04/27/22 and revised on 11/30/22. The goal was that Resident #92 would remain free of skin tear and/or bruising x 90 days with a target date of 03/08/23. (The CP did not address the actual left eye bruise, or other documented ecchymotic areas) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/22/23 at 10:33 AM, the Director of Nursing (DON) was interviewed, in the presence of the survey team regarding what the process would be if a bruise was identified on a resident. The DON stated that an incident report would be completed, interviews would be conducted, and an investigation would be completed. The DON stated that she had been employed at the facility since October 2022. The surveyor inquired regarding if an investigation would be completed for a reddened area that was found on a resident. The DON stated, absolutely, it would be an investigation. The surveyor inquired regarding any incidents that had occurred with Resident #92 in June 2022. The surveyor asked the DON if there would be any time that the DON would not be aware of any incidents, and the DON stated there shouldn't be any situations that she would not be made aware of. The surveyor asked what an SBAR form was completed for. The DON stated that was something that helped when the physician was called. The surveyor asked if the DON was aware of the documentation regarding the red cheek on 12/11/22. The DON stated that she was not aware of that situation and when asked if she should have been, she responded yes. The surveyor inquired to the DON why she should have been made aware of the red cheek documentation. The DON stated she would look into that because we want to make sure there is no allegations of abuse and if it was medical, we would look into that and she stated, I don't have an incident report on it [red cheek]. On 02/22/23 at 10:42 AM, the surveyors interviewed the DON regarding the purpose of a care plan. The DON stated the care plans were for the interventions needed to manage the care of the residents. On 02/22/23 at 11:08 AM, the surveyor inquired to the DON regarding the purpose of having the injury of unknown origin policy. The DON stated the injury of unknown origin policy was for bruises of unknown origin, unless they were sure where an injury came from and were provided the example of how it could be explained or how it happened vs. an unwitnessed injury. On 02/22/23 at 1:00 PM, the DON provided the surveyor with a copy of an incident report dated 06/30/22 at 8:15 AM, and signed by an Registered Nurse (RN #1) for an incident that occurred with Resident #92. The document revealed: Incident Description: During AM [morning] a care staff member noted purple discoloration to resident's left eye lid, skin intact, and no bleeding noted. Resident Description: unable to state how [he/she] got it. Description of Immediate Action Taken: placed cold compress for 15 minutes, Witnesses: no witnesses found. Injury Type no injuries observed at time of incident, The Injury Location and Injury Type sections on the form were left blank. Two statements were attached to the incident report which revealed Date of Event: 06/30/22 Regarding: Left eye discoloration, Statement: This morning around 8 AM, the CNA called me to show that the resident had a left eye bruise. Noted dark purple in color, skin intact no bleeding. No complaint of pain and discomfort. Resident stated that didn't know what happened. Placed cold compress for 15 minutes. Needs attended, will monitor, signed and undated by RN #1. A second statement revealed Date of Event: 06/30/22, regarding Left eye discoloration. Statement: Around 8:15 AM, I came to resident's room, before giving [him/her] care. I noticed that [his/her] left eye has a bruise. I immediately called the nurse to see and assess. Signed and undated by a CNA. On 02/23/23 at 11:59 AM, the surveyor asked the DON what the injury on 06/30/22 would be classified as and the DON confirmed it was a bruise of unknown origin. The surveyor inquired who would be interviewed regarding an investigation. The DON stated there should have been a look back period with the Nurse Aides for ruling out abuse and then stated no, and confirmed that there was no look back period regarding any statements obtained, and nothing else was found by the DON regarding any other statements from the nurse aides regarding the 06/30/22 bruise of unknown origin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/23/23 at 12:09 PM, the surveyor requested, from the Licensed Nursing Home Administrator (LNHA), the facility investigation policy and any policies related to injuries of unknown origin. At 12:23 PM, the LHNA provided an accidents/incidents and care plan policy to the surveyor. On 02/24/23 at 8:18 AM, the LNHA and in the presence of two surveyors provided an investigation file for Resident #92 which included a reportable event record dated 07/02/22 for a date of event at 06/30/22 (2 days later) regarding an unwitnessed injury that was reported. There were three completely different statements attached to the document then had been provided to the surveyor on 02/23/23 at 1:00 PM. The statements revealed: Date: 06/30/22, Re: Resident moves frequently while in [his/her] bed, sleeping with [her/his] face near the bed rails and tends to lie with [his/her] hand on [his/her] face causing pressure has been noticed. Signature, undated and not titled. A second statement revealed Date: left blank, revealed received resident in bed, alert and responsive . resident is active in bed and has poor sense safety. Sleeps at intervals, moves around in bed. Received extensive care by CNA for incontinent of urine. CNA did not report to me of any marks on resident. Signed, undated by CNA. Third statement revealed Date of Event: 06/30/22, resident moves a lot in bed. I have seen [him/her sleeping with [her/his] face near the side rails, signed, undated and untitled. The surveyor asked the LNHA what she would expect to see completed for an investigation. She stated the four what's, what happened, when, why, and what are you doing about it. The LNHA stated the discoloration was found, all staff that cared for the resident were interviewed, the nurse and the CNA statements were provided to surveyor as original statements, and then the LNHA stated she found additional statements for the investigation that were from a Nurse and CNA that had taken care of the resident before. The surveyor asked the LNHA how the conclusion of the investigation was then determined. The LNHA stated that the resident moved around in bed, so it was concluded it was the side rail that caused the injury. The surveyor asked if abuse had been ruled out, and the LNHA stated it was ruled out because the resident moved in bed. The surveyor asked the LNHA if any residents had been interviewed to determine there was no potential abuse. The LNHA stated that no other residents were interviewed and typically we interview other residents to see how care givers are and ensure there are no issues. The surveyor asked if there was a written assessment of the bruise, and the LNHA stated would find and provide it, the surveyor also requested any interdisciplinary team review and documentation. The LNHA stated since the resident was seen sleeping near the siderail the night before, that was how the conclusion was determined and the LNHA again, confirmed that there had been no other interviews completed with any other residents regarding the care provided by the staff. The surveyor inquired if any documented physical assessments were completed for other residents who were not alert or confused and also cared for by the same staff and the LNHA stated there were no body checks completed for any residents. The LNHA stated in this case we came to the conclusions because the resident was seen leaning up against a side rail and due to blood thinner use. The LNHA stated typically we do interview other residents, when asked about body assessments completed the LNHA stated staff would have been able to see other residents and did not further elaborate. The LNHA did not provided the surveyor with a documented assessment of the bruise or interdisciplinary documentation of the incident. On 02/24/23 at 9:05 AM, the LNHA confirmed there was a nursing note completed on 06/30/22 regarding ecchymotic areas on the body, and there was no additional documentation provided regarding the investigation, or documented evidence regarding assessment of areas located on body, or size of bruise on eye. On 02/24/23 at 10:06 AM, the surveyor inquired about the purpose of care plans. The DON stated that the purpose was to identify a resident's needs and implement nursing interventions to keep a resident safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/24/23 at 10:12 AM, the surveyor interviewed the DON regarding any assessments of the bruise or ecchymotic areas on Resident #92. The DON stated typically with an assessment of a bruise, measurements would be documented and there was no documentation regarding the multiple ecchymotic areas. The surveyor asked if that should be investigated and the DON stated, yes, the pieces of the puzzle were not sticking together and typically a whole-body skin check would have been completed when bruises were identified. A review of the Accident/Incidents Policy, Effective 06/01/96, Revised 10/24/22, revealed an incident is defined as any occurrence not consistent with the routine operation of the Center or normal care of the patient. An incident can involve a visitor or staff member, malfunctioning equipment .4.4 When conducting an investigation, the Administrator, DON, or designee will make every effort to ascertain the cause of the accident/incident; Initiate of timeline chronology, Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident . A review of the Abuse Prohibition Policy, Effective 06/01/96, and Reviewed 10/24/22, revealed the center will implement an abuse prohibition program through .Identification of possible incidents or allegations which need investigation, Investigation of incidents and allegations .Injuries of unknown source are defined as an injury with both of the following conditions: The source of the injury was not observed by an person or the source of the injury could not be explained by the patient; and the Injury is suspicious because of the extent of the injury or the location of the injury (e.g./ the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.; 6.4 Injuries of unknown origin will be investigated to determine if abuse or neglect is suspected. NJAC 8:39- 27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38079 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to update comprehensive patient-centered care plans for: a.) a resident with suicidal ideation, b.) a resident on a hypotensive medication, and c.) a resident with a diagnosis of pneumonia requiring antibiotics. This deficient practice was identified for 3 of 23 residents (Resident #71, #95, and #26) reviewed for Care Planning (CP) and was evidenced by the following: a.) On 02/09/23 at 8:21 AM, the surveyor observed Resident #71 sitting on the side of the bed reading the newspaper. The surveyor observed the resident's urinary catheter collection bag was not in a privacy bag. At that time, the Registered Nurse (RN) was outside the room in the hallway with the surveyor and stated the resident had behaviors including taking the urinary collection bag out of the privacy bag. A review of the medical records for Resident #71's included an Admission Record which revealed the resident was recently readmitted with diagnoses which included, but were not limited to, paranoid schizophrenia, need for assistance with personal care, bipolar disorder, and major depressive disorder. A review of the Order Summary Report, revealed the following orders: dated 01/20/23 for Escitalopram Oxalate (an anti-depressant) 10 milligram (mg) give one tablet by mouth one time a day for depression; Lamictal (anti-epileptic) 150 mg give one tablet by mouth two times a day for bipolar disorder; and Olanzapine (an anti-psychotic) 20 mg give 20 mg by mouth at bedtime for bipolar disorder. A review of a, Risk Assessment note dated 12/15/22, included, but was not limited to: Describe Suicidal Ideation: Yesterday (12/14/22) I had a moment where I wanted to commit suicide. Risk Factor: HX (history) of suicidal behaviors, severity of psychiatric symptoms. Identify who at facility was informed that patient is currently a danger to self: SW (Social Worker) [name redacted]. The Risk Assessment was completed by a SW therapist who worked for an outside facility. A review of the on-going CP, including resolved focus areas, last care plan review completed 01/01/23, failed to include suicidal ideation, or goals and interventions related to suicidal ideation. On 02/22/23 at 10:43 AM, the surveyor interviewed the Director of Nursing (DON) who stated the purpose of the CP was so the entire facility staff would be aware of the care a resident needed. She stated all staff should be aware of a resident's care plan and were able to read the CP on the electronic medical record. On 02/23/23 at 8:50 AM, the DON stated, No the care plan was not updated to include Resident #71's suicidal ideation. A review of the facility provided, Suicide Precautions, revision date 06/01/21, included, but was not limited to 5. Update care plan. A review of the facility provided, Behaviors: Management of Symptoms, revision date 10/24/22, included, but was not limited to 8. Document: 8.1 behavior goals, interventions, evaluation within the comprehensive patient-centered care plan. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b.) On 02/13/23 at 9:08 AM, the surveyor observed Resident #95 talking to the nurse in the 2nd Wing hallway. At 9:49 AM, the surveyor observed Resident #95 sitting in a chair by the kitchen was out of the view of the nursing staff. A review of Resident #95's Admission Record revealed the resident had been admitted with diagnoses including, but not limited to, idiopathic hypotension (low blood pressure) and muscle weakness. A review of the Order Recap Report revealed an order dated 11/03/22, Midodrine (medication to increase blood pressure) 5 mg give one tablet by mouth three times a day for low blood pressure. Hold if SBP (systolic blood pressure) > (above) 120 mm hg (millimeters of Mercury). A review of the on-going CP revealed there was no documented focus area for hypotension, or goals or interventions for hypotension including the use of Midodrine. On 02/24/23 at 9:59 AM, the surveyor and DON reviewed Resident #95's CP. The DON stated, there should have been a care plan to address the Midodrine. She further stated she would oversee care plans and could not recall if she reviewed Resident #95's CP. The DON stated that the purpose of the care plan was to manage resident care and know what goals were needed to keep residents safe. The DON stated that if Midodrine was administered outside the parameters ordered, Resident #95 could experience a hypertensive crisis (a sudden spike in blood pressure, a medical emergency that could lead to organ damage or be life-threatening). c.) On 02/24/23 at 10:18 AM, the surveyor observed Resident #26 in bed with the head of the bed elevated. Resident #26 stated he/she had pneumonia (PNA) and had been on an antibiotic. On 02/24/23 at 10:21 AM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) caring for Resident #26, stated Resident #26 had pneumonia and was on an antibiotic. She stated the staff would monitor side effects and vital signs. She further stated we don't do care plans, but the supervisors would include the antibiotic and pneumonia to the resident's care plan. If the resident had any problems, we would let the physician know and tell the next shift. A review of the medical records for Resident #26's included an Admission Record which revealed the resident had diagnoses which included, but were not limited to, sepsis, bacteremia, and chronic respiratory failure. A review of the Physician Progress Note (PN) dated 01/30/23, revealed a change in condition and noted bacterial pneumonia. A nursing PN dated 01/31/23, which revealed infection chest x-ray positive for PNA. Antibiotic started for PNA. A review of the Medication Administration Record (MAR) dated January 2023, revealed the resident had been started on 01/31/23 on Doxycycline (an antibiotic) 100 mg give one tablet by mouth two times a day for PNA for 5 days. A review of the February 2023 MAR revealed the resident completed the antibiotic on 02/04/23. A review of the on-[NAME] comprehensive resident-centered Care Plan failed to document a focus area for pneumonia or the antibiotic use, a goal, or any interventions associated with pneumonia and the physician ordered antibiotic. A review of the facility provided, Clinical Record: Charting and Documentation policy and process, revised 02/01/23, included, but was not limited to: Purpose: to provide a complete account of the patient's total stay from admission through discharge, provide information about the patient that will be used in developing a plan of care, and as a tool for measuring the quality of care provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided, Person-Centered Care Plan policy revised 10/24/22, included, but was not limited to: The interdisciplinary team . will establish the expected goals and outcomes of care, the type, amount frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. Documentation will show evidence of patient's goals and preferences. Purpose: to attain or maintain the patient's highest practicable physical, mental and psychosocial wellbeing. To promote positive communication between patient, patient representative, and team to obtain the patient's input into the plan of care, ensure effective communication, and optimize clinical outcomes. 4. A comprehensive person-centered care plan must be developed for each patient and must describe the following: 4.1 services that are to be furnished. 6.1. the care plan must be customized to each individual patient's preferences and needs. 6.2. if there is not a care plan available to meet a patient's needs, staff may develop one using the custom care plan in [redacted] (electronic medical record). 7. Care plans will be: 7.1. communicated to appropriate staff, patient, patient representative, family. 7.2. reviewed and revised by the interdisciplinary team after each assessment, and as needed to reflect the response to care and changing needs and goals. 7.3. documented on the Care Plan evaluation notes. The facility failed to follow their policies. NJAC 8:39-11.2 (i); 27.1 (a)(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on observation, interview, record review and review of other pertinent documentation, it was determined that the facility failed to follow professional standards of clinical practice with respect to a.) medication administration and documentation, b.) follow the facility's policy/protocol on discarding controlled substances, and c.) follow standards of clinical practice and executing orders as prescribed by the physician. The deficient practice was identified for 4 of 8 residents during medication pass observation (4 unsampled residents); 1 of 6 residents (Resident #95) reviewed for medication parameters; and 3 of 3 sampled residents reviewed for care (Resident # 315, #88 and Resident #95). The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. a.) On [DATE] between 7:43 AM through 8:36 AM, Surveyor #1 accompanied Registered Nurse (RN) #1 on the 2nd Wing during medication administration pass and observed the following: At 7:43 AM, RN #1 began to prepare medications to administer to unsampled resident (UR) #1. RN #1 prepared two pills of one medication and put them into a medication cup. RN #1 and Surveyor #1 went to UR #1's room where we both observed that UR #1 was in the bathroom and unavailable to receive medications. RN #1 went back to the medication cart and placed the medication cup with two pills into the top drawer of the medication cart. There were no markings on the medication cup to identify the intended resident or the medication in the cup. At 7:47 AM, RN #1 proceeded to prepare medications to administer to UR #2. RN #1 poured three pills into a medication cup. RN #1 and Surveyor #1 proceeded to UR #2's room. At 7:50 AM, UR #2 was observed swallowing his/her medications. At that time, RN #1 stated, I know it's 10 minutes early. RN #1 also failed to immediately document administration of the three pills. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 7:52 AM, RN #1 proceeded to prepare medications to administer to UR #3. RN #1 obtained one pill, crushed it per physician order, and administered the medication to UR #3 at 7:55 AM. RN #1 failed to immediately document administration of the medication. On [DATE] at 8:22 AM, RN #1 stated that she was told to keep pills in the medication cart if the resident was not ready for them. RN #1 was unable to identify who instructed her to do that. Surveyor #1 asked RN #1 what the time frame process was to administer medication. RN #1 stated, it was only 10 minutes. When asked about signing for medications administered to residents, RN #1 stated, Oh I forgot to sign. I'll do that now. On [DATE] at 9:40 AM, during an interview with Surveyor #1, the Director of Nursing (DON) stated that the process for medication was for the nurse to make sure the resident was available for medication administration before pouring the medication. If not, the nurse should have discarded the medications, the medications should not be kept in the drawer of the medication cart because of infection control and also the nurse could mix up the medications and administer them to the wrong resident. The DON further stated that medications may be administered up to one hour before or one hour after the prescribed medication time. The DON stated that nurses were required to sign the medication as administered as soon as the medication was taken by the resident. On [DATE] at 10:32 AM, Surveyor #1 reviewed the medical record for Resident #95. A review of the Admission Record revealed Resident #95 was admitted with diagnoses which included, but were not limited to, idiopathic hypotension, Type 2 Diabetes Mellitus, and muscle weakness. A review of the Admission Minimum Data Set (MDS), an assessment tool, dated [DATE], revealed a Brief Mental Status (BIMS) score of 15 out of 15 indicative of intact cognition. A review of the on-going Care Plan (CP) failed to document a focus area of hypotension (low blood pressure), goals, or interventions. A review of the Order Recap Report revealed a physician's order dated [DATE], for Midodrine (medication to raise blood pressure) 5 milligram (mg) 1 tablet by mouth three times a day for low blood pressure. Hold if SBP (systolic blood pressure) > (over) 120 mm hg (millimeters of mercury). A review of the Medication Administration Record (MAR) revealed the following: [DATE], date ranging from [DATE] through [DATE], Midodrine was administered to the resident outside of the prescribed parameters 4 out of 83 opportunities. [DATE], date ranging from [DATE] through [DATE], Midodrine was administered to the resident outside of the prescribed parameters 3 out of 93 opportunities. February 2023, date ranging from [DATE] through [DATE], Midodrine was administered to the resident outside of the prescribed parameters 5 out of 69 opportunities. On [DATE] at 10:08 AM, during an interview with Surveyor #1, a Licensed Practical Nurse (LPN) stated Resident #95 had an order for parameters to administer the Midodrine. She stated there if SBP reading was over 120 mm hg, do not give the medication. She stated giving the medication would cause hypertension (elevated blood pressure) and the resident could have a hypertensive crisis. LPN stated some problems we have to monitor with having low blood pressure would be dizziness. On [DATE] at 10:43 AM, during an interview with Surveyor #1, the DON stated a resident CP would be developed so the entire staff was aware of the care a resident needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:59 AM, during an interview with Surveyor #1, the DON stated Resident #95 was on Midodrine and there was a hold or if the SBP read over 120 mm hg. She stated that if given outside of the ordered parameters, the medication could cause the resident to have a hypertensive emergency. Surveyor #1 and the DON reviewed Resident #95's MARs. The DON stated, I see it (medication) it's being given multiple times outside of the parameters. 27193 b.) During a medication administration observation on [DATE] that began at 8:35 AM, Surveyor #2 observed the Licensed Practical Nurse (LPN #1), while she was preparing the following medications to administer to an unsampled resident. Bactrim ,d+[DATE] mg a broad spectrum antibiotic Amiodarone 100 mg Metoprolol tartrate 50 mg hypertensive medication ASA 81 mg blood thinner Probiotic 1 caps Miralax 17 gm used for constipation Senna 2 tabs for constipation Hydrocodone ,d+[DATE] 1 tab (opiate narcotic) for pain. LPN #1 entered the room and informed the resident that all the medications, including the narcotic were in the medication cup. The resident took some of the medications with water, then dropped some of the medications on the sheet. One of the medications observed on the sheet, was a narcotic (Hydrocodone , d+[DATE] milligrams). LPN #1 then informed the surveyor that she had to discard the medications and pour another set of medications. LPN #1 then reached for the drug buster (drug disposal system) that was located at the bottom of the medication cart and disposed of all of the medications, including the narcotic, into the drug buster. That same day at 9:30 AM, Surveyor #2 requested from the DON, the facility's policy for discarding controlled substances. On [DATE] at 10:30 AM, Surveyor #2 interviewed LPN #1 regarding the protocol for discarding controlled substances. The LPN stated that all controlled substances [narcotics] were to be witnessed and discarded with two nurses present. On [DATE] at 11:15 AM, the Assistant Director of Nursing/ Infection Control Preventionist (ADON/IP), approached Surveyor #2 and asked if Surveyor #2 would sign the controlled substance medication declining inventory sheet since the surveyor observed LPN #1 discard the hydrocodone in the drug buster. Surveyor #2 informed the ADON/IP that surveyors could not sign the declining inventory sheet as they were not employed by the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided form titled, Disposal/Destruction of Expired or Discontinued Medication dated [DATE], last revised [DATE], indicated under Procedure #12, Controlled Substances: Facility should destroy Schedule II-IV controlled substances as detailed with the following exceptions: 12.1 Facility should destroyed controlled substances in the presence of a registered nurse and a licensed professional in accordance with Facility policy or applicable law. 12.2 Destruction of controlled medications should be documented on the controlled medication count sheet and signed by the registered nurse and witnessing licensed professional who should record: 12.2.1 Quantity destroyed; 12.2.2 date of destruction; and 12.2.3 Signature of registered nurse and Licensed professional. The policy was not being followed. c.) On [DATE] at 12:25 PM, Surveyor #2 entered Resident #88's room, and observed 2 Certified Nursing Assistant (CNAs) at the bedside providing care. The resident was positioned on the right side. The surveyor observed a left nephrostomy dressing located on the resident and was dated [DATE]. Surveyor #2 reviewed Resident #88's Treatment Administration Record (TAR), with the nurse and noted that staff had signed on ,d+[DATE] and [DATE] that the nephrostomy dressing was changed. Resident #88 was admitted to the facility with diagnoses which included, but were not limited to, metabolic encephalopathy, urinary tract infection, ureteral calculus obstruction and pressure ulcer of sacral region. A review of the Quarterly MDS, an assessment tool, dated [DATE], reflected that Resident #88 was totally dependent on staff for care. A review of Resident #88's, Order Summary Report (OS) dated [DATE] timed 7:00 AM, showed that Resident #88 had an order to change bilateral nephrostomy site dressing every day shift, every other day for nephrostomy care. Cleansed bilateral nephrostomy site with VASHE (wound solution cleanser), and cover with dry protective dressing every other day. On [DATE] at 12:45 PM, during an interview with Surveyor #2, the nurse who signed the TAR on [DATE] on the 7:00- 3:00 PM shift stated that she signed the TAR but forgot to change the dressing. The nurse who signed the dressing on [DATE] did not have any comment as to why she had signed for a dressing change that she had not performed. On [DATE] at 11:15 AM, Surveyor #2 shared the above concerns with the DON. A review of the facility provided, Clinical Competency Validation Medication Administration, dated [DATE], revealed RN #1 was deemed competent in administering oral medications to residents. The Competency included, but was not limited to, introduces self to patient and verifies patient identification, and stays with patient until the drug has been swallowed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility provided, Registered Nurse Job Description, revised [DATE], included, but was not limited to, Position Summary: .operates within the scope of practice defined by the State Nurse Practice Act. Implementing Care: 3.4. administers medications per physician orders. Job Skills: 2. Knowledge of medications, their proper dosage, and expected results. A review of the facility provided, Licensed Practical Nurse Job Description, revised [DATE], included, but was not limited to, Position Summary: .delivers efficient and effective nursing care; operates within the scope of practice defined by the State Nurse Practice Act. Provision of Direct Patient Care: 3.1. administers medications per physician orders. 4. Monitors patient care provided by unlicensed staff: 4.4. ensures that assigned tasks are performed in accordance with policies and procedures. Job Skills: 2. Knowledge of medications, their proper dosage, and expected results. A review of the facility provided, General Dose Preparation and Medication Administration policy and procedure, revised [DATE], included but was not limited to Procedure: 3. Dose Preparation: 3.2. should only prepare medications for one resident at a time. 3.10. staff should not leave medications unattended. 4. Prior to administration of medication, 4.1 facility staff should: 4.1.1. verify each time a medication is administered that it is the correct medication, correct dose, correct route, correct rate, and at the correct time. 5.4 administer medications within timeframe specified. 6.1 document necessary medication administration (when medications are given). A review of the facility's policy titled, Nursing Documentation, initiated [DATE] and last revised [DATE] revealed the following: Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's patient condition situation and complexity. Purpose:to communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Practice Standards Nurses will not document services that were not performed; Document services before they are performed; Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures. The policy was not being followed. NJAC 8:,d+[DATE].4; 27.1 (a); 29.2 (d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to provide personal hygiene and provide timely assistance for 6 of 6 residents (Resident #1, #35, #45, #66, #88 and Resident #57) reviewed who required assistance with Activities of Daily Living (ADLs). The deficient practice was evidenced by the following: On 02/08/2023 at 8:50 AM, the surveyor toured the 3rd Wing of the with staff and observed the following: 1.The surveyor entered Resident #35's room with a Certified Nurse Aide (CNA). Resident #35 was observed in bed resting. The CNA informed the resident of the task and the CNA proceeded to turn the resident over. The surveyor, along with the CNA observed that Resident #35 was soaked with urine and was wearing two incontinence briefs. The breakfast tray was noted on the bedside table that was untouched. On 02/08/23 at 09:10 AM, during an interview with the CNA, she stated that the facility was shorthanded. She further added that she did not check the resident for incontinence during her first round or resident checks. The CNA stated she knew that most of the residents were wearing two incontinent briefs. The CNA added, most of the time in the morning the residents would be soaked with urine and the bedding would also be soaked with urine. On 02/08/23 at 09:45 AM, the surveyor returned to the Resident #35's room and observed the breakfast tray was still on the table and was untouched. Review of the medical record revealed according to the Admission Record, Resident #35 was admitted to the facility with diagnoses which included but was not limited to; multiple sclerosis, quadriplegia, muscle weakness and disease of spinal cord. The Quarterly Minimum Data Set (MDS), an assessment tool dated 12/17/22, revealed that Resident #35 required extensive assistance from staff with ADLs (related to personal care activities including bathing, dressing, eating, using the toilet). 2. On 02/08/2023 at 9:15 AM, the surveyor entered Resident # 57's room. The surveyor observed the resident was in bed. The resident's arms were folded and rested on the chest area. The lower extremities were contracted. The resident had his/her eyes open and was looking around. Resident #57 was being administered a tube feeding at that time. The CNA was present and put the feeding tube on hold, informed the resident of the task and proceeded to turn the resident. The surveyor observed that the bedding was wet, and Resident #57 was wearing two incontinent briefs. Resident #57's nails appeared jagged and were soiled with debris underneath all nail beds. The fingers were curled into the palm of both hands. There were no hand roll devices in place. An interview with the CNA revealed that the facility had been shorthanded since the pandemic [2020]. The CNA stated when she first started back in 1994, she used to have 7 to 8 residents on her assignment. and gradually she was to care for 10 to 12 residents on the 7:00- 3:00 PM shift. She stated lately she cared for 30. She stated the CNAs were unable to provide the care that was required by the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #57's medical record revealed the resident was admitted to the facility with diagnoses which included but was not limited to; acute respiratory failure with hypoxia, cerebral palsy, quadriplegia, and other seizure. The Annual MDS dated [DATE], reflected that Resident #57 was totally dependent on staff for all ADL. A review of Resident #57's Care Plan for incontinence care initiated on 01/30/19 and revised on 12/11/20, revealed that Resident #57 was unable to participate in a cognitively or physically in a [bowel/bladder] retraining program due to cognitive loss. Resident # 57 was incontinent of bowel and bladder functions and was at risk for skin impairment. The goal was for Resident #57 to have incontinence care needs met by staff to maintain dignity and comfort and to prevent incontinence related complications. The interventions included: for staff to assist with perineal care as needed and monitor for skin redness/irritation and report as indicated. Utilize appropriate continent products. 3. At 9:30 AM the surveyor entered Resident #45's room with the CNA and observed the resident in bed. The resident was awake and alert and consented to be checked. The resident was wet and was wearing double incontinent briefs. The resident's nails were long and jagged. The CNA stated that only one CNA worked the night shift and could not provide incontinent care to all residents every two hours. On 02/08/23 at 10:15 AM, the surveyor entered Resident #45's room a second time with the CNA. During the care tour, Resident #45 was observed to be soaked with urine. Resident #45's fingernails were long and jagged with a black film noted underneath the fingernails. On 02/13/22 at 10:28 AM, the surveyor again observed the resident in the Atrium waiting for the lunch meal. The surveyor inquired if Resident #45 would like their fingernails to be cleaned and trimmed, he/she stated, yes. A review of the medical record revealed Resident #45 was admitted to the facility with diagnoses that included, but were not limited to major depressive disorder, muscle weakness, unspecified dementia, repeated falls and unsteadiness on feet. A review of the Quarterly MDS, dated [DATE], revealed that Resident #45 was dependent on staff for care. The Care Plan for ADLs initiated 12/22/17 revised 10/12/21, revealed that Resident #45 required assistance with ADL care in bathing, grooming, and personal hygiene related to decline in cognition and function. Interventions included that Resident #45 would be provided with extensive assistance of 1 for personal hygiene (grooming). Resident #45 required extensive assistance of 1 for toileting and transfers. The Care Plan for incontinence initiated on 02/03/20, revised 06/28/20, revealed that Resident #45 was unable to participate in a retraining program due to mental status. He/she will go the bathroom when he/she wanted to. The goal was for Resident #45 to have incontinence care needs met by staff to prevent incontinence related complications. Interventions included: Assist with perineal care as needed, use absorbent products as needed. Monitor for skin redness/irritation and report as indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. On 02/08/23 at 10:05 AM, the surveyor entered Resident # 59's room with the Licensed Practical Nurse (LPN). The surveyor observed the resident in bed, the head of the bed was elevated, the resident's eyes were closed. The LPN informed the resident of the task and proceeded to turn the resident. Resident #59 was soaked with urine and was wearing double incontinent briefs. On 02/08/23 at 10:31 AM, the surveyor left the room and interviewed the nurse regarding incontinent care. The nurse revealed that staff were to provide incontinent care every two hours, and as needed. When asked about the double briefs that were observed on multiple residents, she stated that the CNAs had been educated several times regarding putting double briefs on the residents. The LPN further stated that for infection control purpose, residents should not have double briefs on. Review of the medical record revealed Resident #59 was admitted to the facility with diagnoses which included but were not limited to: chronic kidney disease, Alzheimer's disease, and urinary tract infection. Resident #59 received hospice services. The MDS, dated [DATE], reflected that Resident #59 was cognitively impaired, and totally dependent on staff for care. The Care Plan for incontinence care initiated 01/15/19 and revised 05/29/20, revealed that Resident #59 was incontinent of urine at night. Interventions included to check and changed every 3 hours when in bed. Offer/assist with urinal/commode as requested/ needed. Use absorbent products as needed. On 02/13/23 at 10:57 AM, the surveyor checked Resident #59 with the Hospice CNA. The resident was observed to have only one incontinent brief on which was saturated with urine. An interview with the Hospice CNA at that time revealed that Resident #59 did not get out of the bed. She further stated that the facility staff would wait for her to provide care to the resident. The Hospice CNA stated that the resident would be soaked with urine and would have two incontinent briefs on most days. 5. On 02/08/23 at 10:45 AM, the surveyor checked a random room on the 100's Wing. The surveyor knocked on the door and with permission, entered the room, and observed 2 CNAs were at the bedside of Resident #88. The CNA's informed the surveyor that they were about to provide care to the resident. At that time, the surveyor observed that Resident #88 was wearing double incontinent briefs, that was soiled with feces and urine, and the resident was also observed with a pressure sore. Both CNAs stated that they did not provide care yet to the resident and were not responsible for putting two incontinent briefs on the resident. Resident #88's nails were long, there was black film observed under all of the nails, and the fingers of the left hand were curled into the palm of the left hand. There was no hand roll device in place. A review of the medical record of Resident # 88 revealed the resident was admitted to the facility with diagnoses which included but were not limited to: metabolic encephalopathy, urinary tract infection, ureteral calculus obstruction and pressure ulcer of sacral region. The quarterly MDS, dated [DATE], reflected that Resident #88 was totally dependent on staff for care. The Care Plan for ADL initiated 10/10/22 with a revision date of 10/10/22, revealed that Resident #88 required assistance for ADL care in bathing, grooming, personal hygiene, dressing, eating and toileting. The interventions to be implemented included for staff to monitor decline in ADL function, refer to rehabilitation therapy if decline in ADLs is noted. Monitor for complications of immobility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #88's Comprehensive Care Plan had a focus for alteration in nutritional risk related to severe dysphagia. The interventions included but were not limited to, supervise/cue/assist as needed with meals. Resident to be assisted at mealtimes. Do not feed him/her if he/she holds the food in his/her mouth or if he/she is too lethargic. On 02/17/23 at 9:30 AM, the surveyor observed Resident #88 in bed positioned on their back, HOB slightly elevated. breakfast meal tray on the bedside table. Resident #88 attempted to feed self but could not. The surveyor escorted the Registered Nurse (RN) to the room where we both observed that the resident could not reached the food on the tray. The RN confirmed that the resident could not feed self. On 02/21/23 at 9:45 AM, the surveyor observed Resident #88 in bed. The breakfast tray was setup for the resident to eat. The resident attempted to drink the juice and was falling asleep. The breakfast tray was untouched and there was no one supervising the resident at mealtime. The surveyor informed the LPN who was seated at the nursing station that the resident was not eating. The LPN stated that she set up the tray, ensured that Resident #88 could reach the spoon and left the room. At that time the surveyor reviewed the Care Plan with the nurse. The nurse asked the surveyor if the care plan stated supervise and assist with meals as needed, why he/she had to be assisted. The surveyor showed the nurse the documentation where the CP documented Assist with all meals. The nurse stated that she was not aware that Resident #88 needed assistance with meals. On 02/21/23 at 10:35 AM, the surveyor asked the DON how resident care needs were communicated to the staff. The DON stated that the supervisors were to inform staff of any changes in the resident condition. The surveyor then asked the DON how the needs identified on the care plan were communicated to staff. The DON stated that the staff should be aware of the needs identified on the care plan. The surveyor informed the DON that the staff on the unit were not aware that Resident #88 needed to be supervised during meals. 6. On 02/08/23 at 11:46 AM, the surveyor observed Resident #1 seated in a wheelchair in the room. The resident requested to speak to the surveyor. Resident #1 stated that he/she had been residing at the facility for 8 years and had noticed lots of changes. He/she requested to go to bed by 9:00 PM and requested that this information be communicated to the staff. Resident #1 informed the surveyor that the above information was on the care plan and discussed during the quarterly meeting. The resident also stated that he/she needed assistance with transfer and using the bathroom. Staff would say they cannot accommodate his/her request because they were shorthanded. The resident stated that he fell and activate the call light. Resident #1 stated that he/she was on the floor for 20 minutes before staff answered the call light. A review of the medical record for Resident #1 revealed the resident was admitted to the facility with diagnoses which included but were not limited to: major depressive disorder, muscle weakness, unspecified lack of coordination and need for assistance with personal care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS dated [DATE], revealed that Resident #1 was awake and alert and able to make his/her needs known and scored 15/15 on the Brief Interview for Mental Status (BIMS) which was indicative of intact cognition. The Comprehensive Care Plan initiated 02/08/22 with a revision date of 06/06/22, included a focus for falls. The interventions were to have two staff assistance while transferring from bed to the wheelchair and from wheelchair to bed. Minimize risk for falls. Educate staff to ask for help when assisting Resident #1 during transfers since Resident #1, was a two person assist. On 02/24/23 at 9:10 AM, the surveyor escorted the Director of Nursing (DON) to Resident #45's room where we both observed the fingernails were long and jagged and needed to be cleaned. The DON stated that she asked the CNAs to provide nail care on 02/23/24 and was unable to explain why it had not been done. The above concerns with incontinence care, nail care, and assistance with meals were discussed with the facility management during the survey and again on 02/24/23. The DON responded that the staff were in-serviced and no additional information had been provided. According to the Facility Policy titled Activities of Daily Living (ADLs) dated 06/01/96 and last revised 06/01/21, provided by the facility on 02/23/23, the following were documented: Policy: Based on the comprehensive assessment of a resident/patient (hereinafter patient) and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living abilities are maintained or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable. Purpose: To ensure ADLs are provided in accordance with accepted standards of practice, the care plan and the patient's choices and preferences. Practice Standards: 4.2 A patient who is unable to carry out ADLs will receive the necessary level of ADL assistance to maintain good nutrition, grooming, and personal hygiene. The policy was not being followed. Staff indicated that they were short-handed almost every day. Staff was not aware of level of care documented on the care plan. NJAC 8:39-27.2 (b)(f)(g)(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27193 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to: a.) ensure the facility policy for Falls Management and Accidents/Incidents policy was followed to determine the causal factor and interventions were updated to prevent recurrent falls, for a cognitively impaired resident (Resident #45), who was identified as high fall risk, had a history of falls with injury which included a fall on 10/08/21 that resulted in a femur fracture that required hospitalization , a subsequent unwitnessed fall on 05/29/22, and a fall requiring hospitalization on [DATE] after sustaining a hematoma to the head, b.) supervision was provided to prevent recurrent falls c.) implement care plan interventions for a resident (Resident #1) identified as requiring two-persons for transfer, was transferred by one staff on 06/06/22, and sustained a fall during transfer which necessitated transfer to the hospital for evaluation, and d.) immediately implement suicide preventions precautions per facility policy and immediately notify the attending physician in response to a resident (Resident #71) who expressed suicidal ideation. This deficient practice occurred for 3 of 5 residents reviewed for accidents and was evidenced by the following: a) During the initial tour of the facility on 02/08/23 at 9:00 AM, Surveyor #1 entered Resident #45's room and observed the resident in bed. At 10:15 AM, surveyor #1 performed a care tour with the Certified Nursing Assistant (CNA). Surveyor #1 observed the resident in bed. The CNA informed the surveyor that Resident #45 was confused and required staff assistance with care. On 02/09/23 at 12:30 PM, surveyor #1 reviewed the medical record for Resident #45. According to the Admission Face sheet, Resident #45 was admitted to the facility with diagnoses that included but were not limited to;major depressive disorder, muscle weakness, unspecified dementia, repeated falls, and unsteadiness on feet. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used by the facility to prioritize care dated 01/19/23, revealed Resident #45 was cognitively impaired. Resident #45 received a score of 5 out of 15 on the Brief Interview for Mental Status (BIMS), indicative of a severely impaired cognition. Resident #45 was totally dependent on staff for care and required extensive assistance of 1 person assist with bed mobility, transfers, and tilting. A review of the Comprehensive Care Plan, initiated 12/21/17, and last revised 11/08/22, revealed a Focus for falls related to: Cognitive loss, lack of safety awareness, preference to be independent. The Care Plan (CP) revealed that Resident #45 sustained falls at the facility on the following dates: 10/08/21, 05/29/22 and 11/06/22. The Goal was to minimize the risk for falls. Interventions to minimize falls, included: Provide verbal cues for safety and sequencing when needed. Initiated 12/21/17; Utilize night light in room/ bathroom. Initiated 08/13/19; Place call light within reach while in bed or close proximity to the bed. Initiated 06/12/20; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	Remind Resident #45 to use call light when attempting to ambulate or transfer to get in and out of bed. Initiated 06/12/20; Closely monitoring Resident #45, if he/she tired, offer him/her to return to the room for a nap. initiated 02/13/20; Assist out of bed with 1 assist with walker. 10/12/21; Prompted voiding and tilting. Initiated 10/12/21. Encourage to participate in activities that he/she likes. Initiated 10/14/21; Observe for signs and symptoms of abnormal blood pressure including orthostatic blood pressure and promote self-management strategies. Initiated 07/05/22; PT/OT (Physical Therapy / Occupational Therapy) evaluation and treat as needed. Initiated 07/05/22; On 02/15/23 at 8:56 AM, upon entry to the 300's wing, surveyor #1 observed Resident #45 in the resident's room holding onto the wheelchair and was attempting to transfer self to the bed. Resident #45 could not complete the transfer and was very unsteady. The surveyor alerted a staff member who went to the room and assisted Resident #45 into the bed. On 02/16/23, Surveyor #1 requested the falls investigations and a timeline of the falls which included the day, time and location of the falls, and any interventions implemented after each fall. On 02/17/23, the Director of Nursing (DON) provided two fall investigations dated 05/29/22 and 11/06/22. On 02/24/23, the DON provided the fall investigation dated 10/08/21. A summary of the fall incident of 10/08/21, which was dated 10/11/21, revealed that Resident #45 sustained an unwitnessed fall at 1:15 PM in the Atrium. Another resident yelled out that Resident #45 was on the floor. Resident #45 was unable to move their right leg. Resident #45 was transferred to the hospital and admitted with a right femur fracture. Resident #45 was readmitted to the facility on ,d+[DATE]/ 21, with right hip intramedullary rodding. A statement from a staff who was assigned to the 2nd wing revealed that she was on the 2nd wing getting ready for medication administration and heard another resident calling out that Resident #45 was on the floor. A statement from the nurse assigned to the 3rd wing documented, I was in a resident's room and was notified that Resident # 45 was on the floor. A statement from the the CNA assigned to the 3rd wing documented, I was inside assisted with feeding. The nurse called and informed of the fall. Other residents (including Resident #45) were in the Atrium eating lunch, and there was no staff around to monitor the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	An un-witnessed Incident report (a report the facility fills out to investigate an incident) dated 05/29/22 timed 12:55 PM, included the following: Incident Description: Nursing Description: This writer finds Resident #45 sitting up on his/her buttocks in the hallway between room [ROOM NUMBER] and 315. This writer asks what happened. Resident #45 stated, I don't know.Assisted to chair with 2 staff using mechanical lift. Injury Type: No injuries observed at time of incident. There was no witness to the fall. There were no staff statements that would indicate when Resident #45 was last seen/checked. The causal factor was not identified. According to documentation provided by the DON on 02/27/23 the Interdisciplinary Team met and discussed the fall on 05/31/22. The following was documented, Met and discussed the resident's fall. The resident's plan of care updated to reflect, environmental rounds in resident area for safety, to provide education and redirection within limits. Staff will continue to encourage Resident #45 to use call bell to ask for assistance prior to ambulating. Will refer to PT/OT post incident. An Incident report dated 11/06/22 timed 7:15 PM, included the following information: Incident Description. Nursing Description: Resident #45 was seen at 6:30 PM lying on his/her bed. At 7:15 PM, I was notified by CNA that resident was sitting on the floor by his/her room door. Resident #45 is alert and responsive, denies any pain at this time, ROM [Range of Motion] to upper and lower extremities within normal limit. Assisted back to bed via mechanical lift with 2 assist. Once in bed, hematoma (collection of blood), noted on the left upper eyebrow. Resident Description: Resident unable to give description. Immediate action: Physician notified of incident and reminded that Resident #45 is on Eliquis (anticoagulant medication). Order received to send Resident #45 to the hospital for evaluation. An attached note dated 11/06/22 timed 19:15 [7:15 PM] revealed that the resident was admitted to the hospital and was diagnosed with Urinary Tract Infection. On 02/13/23 at 9:55 AM, surveyor #1 interviewed the DON regarding the falls. She stated that she could not locate any fall investigation related to the fall of 10/08/21. The DON stated that she was not working at the facility at that time and could not locate the investigations. When asked about how residents needs were communicated to the staff, she stated that the supervisors were responsible to communicate to direct care staff any change in condition and then update the care plan with any changes. On 02/13/23 at 1:25 PM, the surveyor interviewed a CNA regarding using the residents care plans. The CNA stated that the CNAs did not have access to resident care plans and received report from the nurses and other CNAs. When asked about a CNA care card, the direct care staff was not aware of the care card. On 02/23/23 at 10:30 AM, Surveyor #1 reviewed the electronic progress notes and could not locate any documentation regarding the fall that occurred on 10/08/21. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/24/23 at 11:30 AM, the DON provided the reportable (a report required to be sent to the state department of health) dated 10/08/21, that the fall had been reported to the state, and she could not locate the incident report. The DON indicated she called some staff and was able to get some statements. Statements from residents who could have possibly witnessed the fall were collected on 02/25/23. b) On 02/08/23 at 11:46 AM, Surveyor #1 observed Resident #1 seated in a wheelchair inside the room. The resident requested to speak to the surveyor. Resident #1 stated that he/she had been residing at the facility for 8 years and had noticed a lot of changes. He/she requested to go to bed by 9:00 PM and requested that this information be communicated to staff. Resident #1 informed the surveyor that the above information was on the care plan and had been discussed during the quarterly meeting. The resident also stated that he/she needed assistance with transfer for using the bathroom, and that staff would say they cannot accommodate his/her request because they were shorthanded. The resident stated that he/she fell and was on the floor for 20 minutes before staff answered the call light. On 02/10/23 at 1:19 PM, the surveyor reviewed Resident #1's medical record which revealed: Resident #1 was admitted to the facility with diagnoses which included but were not limited to; major depressive disorder, muscle weakness, unspecified lack of coordination and need for assistance with personal care. The Quarterly MDS dated [DATE], revealed that Resident #1 was awake and alert and able to make his/her needs know. Resident #1 scored 15/15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. The Comprehensive Care Plan initiated 02/08/22, with a revision date of 06/06/22, had a focus for falls related to cardiovascular accident (damage to the brain from interruption of its blood flow), and impaired mobility. The interventions were: Assist Resident #1 with 2 staff assistance while transferring from bed to Wheelchair and from wheelchair to bed. Date Initiated: 02/26/18, and revised 12/11/20, Educate staff to ask for help when assisting Resident #1 during transfers since he/she is a two person assist wheelchair to bed. On 02/23/23 the surveyor requested the investigation report for review. The DON provided 2 incidents reports dated 06/06/22 and 02/14/23. The investigation report dated 06/06/22 contained the following information: Incident Description: Nursing Description. This writer informed by CNA of resident slipped and fell during transfer from bed to the electric chair. Slip was witnessed by CNA. Resident #1 slipped and fell to floor landing on his/her back. No loss of consciousness reported. No complaint of pain. Resident #1 assisted to wheelchair using mechanical lift with 3 staff. Resident Description: I slipped and fell when transferring. Immediate action: Taken to hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	The CNA who was present in the room during the transfer, documented the following: While doing a routine care with the resident. While transferring the resident from the bed to the chair, suddenly the resident lost balance landed on the floor. Immediately I called the nurse. My coworker used the [brand name mechanical lift], to lift the resident assisted to the wheelchair. (The causal factor for the fall was not identified and the Falls Management policy was not followed post fall. The CNA executed the transfer alone and the care plan interventions for Resident #1, who required a 2 person assist for transfer from the bed to the chair and from the chair to the bed, had not been implemented when the fall occurred.) On 02/24/23 at 1:35 PM, the surveyor conducted an interview with the CNA who cared for Resident #1 on 06/06/22. The CNA stated, in the presence of the nurse, that she had not been made aware that Resident #1 required 2 persons assist for transfer from the bed to the chair when she had cared for the resident on 06/06/22 and transferred him/her alone. On 02/24/23 at 12:17 PM, the surveyor discussed the fall incident with the DON and requested any additional information. On 02/27/23 at 9:30 AM, the DON provided a typed incident summary with the following statements: The CNA documented that she did not see anything, I just help the nurse to pick the resident up. Another CNA documented: I was working on wing 1 and the other CNA was wing 3. The nurse assigned to the Wing documented: I assisted the staff with moving the resident from room [ROOM NUMBER] to room [ROOM NUMBER]. The resident was able to get into the room. I walked away from my cart for less than 10-minutes, and I was walking back I heard [him/her] start to yell. On 02/27/23 at 10:30 AM, after surveyor inquiry, the DON provide an updated care plan which indicated that Resident #1 was now a one-person transfer. The Surveyor showed the care plan documentation indicating the resident required a two-person transfer to the DON, the DON did not have any comment. No additional information was provided. Another fall incident dated 02/14/23, documented the following: Incident Description: Nursing Description: Resident was noted on the floor in the room in front of the wheelchair. Resident is alert and oriented and denied hitting his/her head. Resident Description: Resident stated he slipped out of the wheelchair. A statement from the nurse assigned to the 3rd wing, revealed that she found the resident on the floor. There was no investigation included with the incident. On 02/08/23 at 11:46 AM, the resident told the surveyor that he/she slipped from the wheelchair and was on the floor for 20 minutes before he/she could get assistance. The resident had a BINS of 15/15 which indicated the resident was cognitively intact. The facility failed to obtain a statement from the resident to identify the causal factor for the fall and implement interventions to prevent further falls. An interview with the resident, revealed that the facility was shorthanded and could not get staff to assist with transfer when needed. A review of the facility provided form titled, Falls Management, dated 09/15/01, and last revised 06/15/22, indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	Policy: Patients will be assessed for risk of falling as part of the nursing assessment process. Interventions to reduce risk and minimize injury will be implemented as appropriate. Patient experiencing a fall, will receive appropriate care and post fall interventions will be implemented. Purpose: To identify risk for falls and minimize the risk of recurrence of falls. To evaluate the patient for injury post fall and provide appropriate and timely care. To ensure the patient-centered care plan is reviewed and revised according to the patient's fall risk status. Practice Standards: All patients will be assessed for risk of falls upon admission, with reassessment routinely, post fall to determine ongoing need for fall prevention. Implement and document patient-centered interventions according to individual risk factors in the patient's plan of care. Post Fall management: Document circumstances of the fall, post fall assessment, and patient outcome. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the Accidents/Incidents Policy, Effective Date: 06/01/96, Revision Date: 10/24/22 revealed: The Center staff will report, review, and investigate all accidents/incidents which occurred, or allegedly occurred, on or off Center property involving, allegedly involving, a patient who is receiving services. Incident: defined as any occurrence not consistent with the routine operation of the Center or normal care of a patient. An incident can involve a visitor or staff member, malfunctioning equipment, or observation of a situation that poses a threat to safety or security. Purpose: To determine root cause and contributing factors, identify measures to reduce further occurrences and adverse outcomes as part of the Quality Assurance Performance Improvement process. 2.1.4. The physician/APP will be notified of any fall resulting in head injury, suspected head injury, and/or has an unwitnessed fall .2.1.6.2. Document the accident/incident in the patient's chart; Documentation will include all pertinent information, date, time, place, notifications, post-accident/incident evaluation, ongoing evaluations. Reporting: 3.1 All accidents/incidents, witnessed or unwitnessed, will be reported to the supervisor. 3.1.1. Employees witnessing an accident involving a patient will communicate a factual description of his/her findings to the supervisor or the nurse responsible on the unit. 4. Follow-up/Investigation: 4.1. The Administrator or designee will coordinate all investigations. 4.2. The Administrator, DON, or designee will review all accidents/incidents to determine if: 4.2.2. Required documentation has been completed; 4.2.3. Accident/incident has been investigated; 4.2.4. Interventions to eliminate if possible and, if not, reduce the risk of the accident/incident have been identified and implemented. 4.4. When conducting an investigation, the Administrator, DON, or designee will: 4.4.1. Make every effort to ascertain the cause of the accident/incident; 4.4.2. Initiate a timeline chronology; 4.4.4. Conduct witness interviews from all staff and visitors who may have knowledge of the accident/incident; 4.4. 5. Document the root cause and initiate actions to prevent or reduce recurrence of further accident/incident . 38079 c) On 02/09/23 at 8:21 AM, Surveyor #2 observed Resident #71 sitting on the side of the bed reading a newspaper. The Registered Nurse (RN) who was caring for the resident, was standing with the surveyor in the hall. At that time, the RN stated Resident #71 had behaviors. A review of the medical record revealed Resident #71 was admitted to the facility with diagnoses which included but were not limited to; paranoid schizophrenia, bipolar disorder, major depressive disorder, and unspecified intellectual disabilities. A review of the on-going Care Plan (CP), revealed a focus area initiated 09/09/21, and revised on 02/09/23, at risk for complications related to; the use of psychotropic drugs, paranoia thoughts, gets excited and agitated easily, and cries easily. Interventions included but were not limited to; monitor for changes in mental status and functional level and report to MD (physician). A focus area impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: Intellectual/developmental disability. Interventions included but were not limited to observe and evaluate types of changes .decision making ability, ability to express self .impulsivity, mental status and notify physician as needed. A review of the, Therapy Note, dated 12/15/22, documented by a Social Worker (SW) therapist who was not on staff at the facility, included but was not limited to: Diagnosis major depressive disorder and paranoid schizophrenia. Reports history of depression, paranoia, racing thoughts. Past history included psychiatric hospital admission. Patient disclosed suicidal ideation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a Risk Assessment form dated 12/15/22, included but was not limited to: Yesterday I had a moment where I wanted to commit suicide. Risk Factor: Hx (history) of suicidal behaviors, severity of psychiatric symptoms. Pt (patient) verbally agrees to notifying staff immediately if any thoughts, plans, or intentions should arise again. Identify who at the facility was informed that patient is currently a danger to self: SW (Social Worker) [name redacted]. The form was completed by a SW therapist who was not on staff at the facility. A review of the facility provided Progress Notes (PN) ranging from 12/14/22 through 12/25/22, revealed all staff disciplines failed to document Resident #71's suicidal ideation on 12/14/22 that was reported to the facility on [DATE]. The PN failed to document the resident's physician being contacted, any interventions implemented to ensure the residents safety, and any aspect of the facility, Suicide Precautions policy being implemented. A PN dated 12/16/22, documented by the facility SW, failed to address the resident's suicidal ideation that had been reported to her on 12/15/22, per the SW therapist's documentation. However, the note revealed Resident #71 had been missing his/her roommate. The quarterly Minimum Data Set, dated dated dated [DATE], revealed a Brief Interview for Mental Status score of 15/15 indicating the resident was cognitively intact. A review of the facility provided, Behavior Monitoring and Interventions Report, ranging from 11/01/22 through 02/22/23, revealed an entry dated 12/13/22, no behaviors observed. The next entry was dated 12/15/22, no behaviors observed. The facility failed to document if any behaviors were present on 12/14/22 when the resident had his/her suicidal ideation. A review of Resident #71's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 12/01/22 through 12/31/22, revealed the facility failed to document any interventions or monitoring of Resident #71 regarding the suicidal ideation. On 02/22/23 at 9:49 AM, during an interview with Surveyor #2, a CNA who was familiar with Resident #71, stated that the resident has not had any behaviors lately that she had been aware of. On 02/22/23 at 10:00 AM, during an interview with Surveyor #2, a second CNA who was familiar with Resident #71, stated that the resident could be agitated and that she would report any behaviors to the nurses. She further stated she was not aware of any concerns in December 2022. On 02/22/23 at 10:08 AM, during an interview with Surveyor #2, the LPN caring for the resident stated the resident could be nasty and wants things done immediately. The LPN showed the surveyor where behaviors would be documented in the electronic medical record. The LPN further stated she was not aware of any concerns regarding Resident #71 in December 2022. On 02/22/23 at 10:43 AM, during an interview with Surveyor #2, the DON stated a resident's care plan would be so the entire staff would be aware of the resident's care needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	On 02/22/23 at 11:02 AM, the facility Social Worker (SW) and DON were interviewed by the survey team. Surveyor #2 requested the SW show the documentation from where she had been contacted by the therapist SW. The SW was unable to locate any documentation and stated maybe the therapist SW did not inform her. Surveyor #2 showed the SW the note from the therapist SW the documentation that she had been made aware of the notation identify who at facility was informed that patient is currently a danger to self: SW [name redacted] which indicated the facility SW. The DON stated that the suicidal ideation should have been documented to ensure the nurses were monitoring the resident. The DON stated the resident would have been on 15-minute checks. The DON further stated the CP should have been updated, even if the resident stated he/she was not going to do anything, they would still need to be on watch until seen by the psychologist, and that the physician should have been notified. On 02/22/23 at 12:26 PM, during an interview with Surveyor #2, the Nurse Practitioner for the resident's psychiatric medical group, stated she could not remember what happened in December 2022 and was unable to continue to speak to the surveyor. On 02/23/23 at 8:50 AM, during an interview with the survey team, the DON stated that the staff were able to locate a handwritten piece in a drawer at the nurse's station, of paper with 15-minute checks for the resident. A review of the provided paper revealed the resident's name, room number, 12/15 (no year), and staff initials. The paper did not reveal what the resident was being monitored for any behaviors. The DON stated that the 15-minute checks should have been documented in the resident's medical record. The DON further stated, I can't see a note that attending physician was notified. The DON stated that the physicians had remote access to medical records. The survey team reviewed the facility provided, Suicide Precautions procedure revision date 06/01/21, which included but was not limited to: 2. Immediately report behavior/wishes to supervisor and attending physician. 3.1. initiate suicide precautions which included but were not limited to: one-on-one 24-hour supervision; limit/restrict mobility throughout center; remove hazardous items. The DON stated there was no 24-hour supervision initiated; no limited or restricted mobility through the center; and she could not say if any hazardous items were removed. The DON stated that the facility policy should have been followed and that there should have been documentation to ensure the resident was kept safe and what the staff should have been doing. The DON acknowledged the suicidal ideation was not on the 24-hour report to inform the next shift staff. The DON further stated there were no directives or orders provided by the physician because he was not notified. The DON stated there was no investigation completed, but that the SW therapist stated the resident was, ok. When asked if the SW therapist was a practitioner and able to make the decision to order interventions, the DON stated, I don't know. On 02/23/22 at 10:05 AM, during a telephone interview with Surveyor #2, Resident #71's attending physician (MD) stated he was not made aware of the resident's suicidal ideation in December 2022. The MD stated that he would have ordered the nurses to do either 15-minute checks or as needed for the resident who was very independent. The MD stated he would have ordered a psychiatric evaluation and possibly may have sent the resident out for a psychiatric evaluation as he has had to do before. On 02/23/23 at 10:22 AM, during an interview with the surveyor, the DON stated that the SW therapists note dated 12/15/22, revealed low risk. The DON acknowledged that any risk of suicidal ideation should be taken seriously and does not negate that the procedure was not followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility provided, Behaviors: Management of Symptoms, revision date 10/24/22, included but was not limited to: 7. if behavior escalates to the point of being dangerous to self or others, take immediate measures to protect the safety of all patients and staff. 8. Document: 8.1. behavior goals, interventions, evaluation within the comprehensive patient-centered care plan; 8.2. behavior monitoring and interventions in electronic Medication Administration Record. 8.4. notification of physician. NJAC 8:39-27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 27193 Based on observation, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure the facility policy was followed to ensure appropriate care was provided for a resident who required tracheal suctioning for a tracheostomy tube (a surgically inserted tube into the neck to help a person breathe). The deficient practice occurred for 1 of 1 resident reviewed (Resident #57) for tracheostomy care and was evidenced by the following: On 02/13/23 at 10:56 AM, the surveyor attempted to complete an observation of Resident #57. The resident was not in the room, and the staff informed the surveyor that the resident had been transferred to the hospital and was admitted with pneumonia. On 02/23/23 at 9:00 AM, the surveyor reviewed Resident #57's medical record. Record review revealed Resident #57 was readmitted from the hospital on 02/18/23. The diagnoses from the readmission included, but was not limited to; acute respiratory failure with hypoxia and COVID-19. The Annual Minimum Data Set (MDS), an assessment tool dated 01/10/23, revealed Resident #57 was severely cognitively impaired and required extensive to total assistance with all activities of daily living. Review of the hospital discharge Physician Orders dated 02/18/23 for Resident #57, revealed an order for tracheostomy suctioning as needed for increased secretions. Pre/Post Treatment: Evaluate heart rate, respiratory rate, pulse oximetry and breath sounds. The admission intake revealed that upon hospital admission, Resident #57 had to be suctioned for copious amount of purulent drainage from the tracheostomy tube. The New Jersey Universal Transfer Form (NJUTF) (a form that communicates pertinent accurate clinical patient information at the time of a transfer between health care facilities/programs), dated 02/11/23, only indicated that Resident #57 was transferred to the hospital for aspiration (when food or liquid was breathed into the lungs). On 02/23/23 at 9:50 AM, an interview was conducted with the nurse who completed the NJUTF. She revealed she was just covering the unit until the 3:00 PM-11:00 PM nurse reported to work. She went to Resident #57's room to check the resident's blood sugar and observed that the resident's clothing was covered with large amount of undigested feeding [enteral nutrition provided into the stomach by a tube] and the resident had difficulty breathing. She alerted the staff and the physician and Resident #57 was sent out to the hospital for evaluation. The nurse admitted that she did not properly completed the NJUTF. The nurse assigned to the 3rd Wing that day failed to enter any notes in the medical record regarding the resident's condition. On 02/23/23 at 11:00 AM, the surveyor observed Resident #57 lying in bed with humidified oxygen being administered at 5 liters per tracheostomy collar via oxygen concentrator. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #57 was coughing and large amounts of secretions were observed dripping into the tracheostomy collar (medical device used to secure a tracheostomy tube). The surveyor alerted a staff who was in the hallway who then in turn alerted the nurse. The nurse entered the room and informed the surveyor that Resident #57 was always congested and did not need to be suctioned. The nurse then left the room and returned with the fingertip pulse oximetry (oxygen saturation monitor) and checked Resident #57 oxygen saturation. The nurse reported that the oxygen saturation was 97%. The nurse was about to leave the room when the resident started again began coughing. The nurse then stated, now I can hear the gurgling sound. The nurse looked inside the resident room, the suction machine was turned on with the connection tubing attached. The nurse then could not locate the supplies needed to suction the resident. The nurse then left the room and returned with two connection tubes, a disposable tracheostomy kit and sterile water. The nurse then informed the surveyor that Resident #57 had been transferred from the 4th Wing that morning and the staff failed to transfer the supplies. On 02/23/23 at 11:15 AM, the surveyor observed tracheostomy care for Resident #57 and the following was observed: the nurse donned (put on) gloves and did not put on a PPE gown (she was wearing an N95 respirator and a face shield), without first setting up a sterile field, she opened the sterile water and the tracheostomy kit and next removed the tracheostomy collar. She removed the soiled gloves, applied the sterile gloves from the tracheostomy kit, without first performing hand hygiene, and proceeded to suction the tracheostomy. Large amounts of secretion were observed inside of the connection tubing as she continued to suction. She then removed the disposable cannula and replaced it with a new cannula. The Nurse then reapplied the tracheostomy collar, rinsed the suction tubing and discarded it in the receptacle bin at the bedside. The nurse then went to the bathroom, washed her hands and left the room. The nurse failed to perform hand hygiene after removing the soiled gloves and prior to suctioning the resident, she did not check the tracheostomy site and she did not change the fenestrated dressing that was observed soiled with secretions. The nurse did not clean the tracheostomy collar and she did not reevaluate the resident after the procedure was completed, or inspect the stoma (opening) site. The dressing that was soiled with mucus was not replaced. On 02/23/23 at 11:40 AM, an interview was conducted with the nurse regarding the observed tracheostomy care. She stated that she had received in-service training and education on tracheostomy care in the past and the facility had a respiratory therapist on board that could be reached if needed. On 02/23/23 at 11:50 AM, an interview was conducted with the Director of Nursing (DON) regarding the observed tracheostomy care. The DON stated that the facility had a policy and her expectation was that the nurse would follow the policy. A review of the facility provided procedure for tracheostomy suctioning dated 01/01/04, last revised 07/15/21, revealed that the following steps were to be followed: Turn on suction machine. Remove gloves and perform hand hygiene. Place suction kit on the bedside table. Open wrapper and use as sterile field. Fill rinse cup with sterile saline or water. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish one sterile and one non-sterile hand. Designate your dominant hand as the sterile hand. Put on sterile gloves. When suctioning is complete, remove gloves and cleanse hands. Put on gloves. Remove soiled dressing and inner cannula and discard in waste bag. Loosen trach holder enough so that you are able to maneuver under the trach (tracheostomy) but not much that you can risk decannulation. Evaluate the condition of the stoma. Cleanse under trach (tracheostomy) holder and secure. Place drain sponge under trach (tracheostomy) tube neck plate, pulling the ends up under the neck and the trach (tracheostomy) holder. Evaluate patient's respiratory rate, heart rate, breath sounds, pulse oximetry, and cough effort. Assist patient to a comfortable position. Remove PPE (Personal Protective Equipment) and perform hand hygiene. During a second interview with the nurse in the presence of another surveyor on 12/23/23 at 12:15 PM, she confirmed that after receiving the resident from the other wing, she did not fully assess the room to ensure all the supplies needed to perform tracheostomy care were in place. When inquired regarding the tracheostomy site she stated that could visualize the stoma without removing the dressing. On 02/27/23 at 9:50 AM, the DON informed the surveyor that the nurse had been re-educated on tracheostomy care. NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 27193 Based on observation, interview, record review, and document review, it was determined that the facility failed to ensure sufficient nursing staff was in place to ensure resident's highest practicable well-being was maintained by failing to ensure: a.) appropriate incontinence care was provided for 6 of 6 residents reviewed (Resident #35, #57, #88, #45, #59, #88) on 2 of 4 resident Wings (Wing 1 and Wing 3), b.) residents were provided with nail care and hygiene services for 3 of 5 residents (Resident #57, #45, #88) reviewed on 2 of 4 resident Wings (Wing 1 and Wing 3), and c.) appropriate nursing and related services required for a resident who required assistance with meals for 2 of 5 residents reviewed (Resident #35 and #88), on 2 of 4 resident Wings (Wing 1 and Wing 3) to meet the residents individual needs. This deficient practice has the potential to affect all residents and was evidenced by the following: Refer to: F677 and F689 On 02/08/2023 at 8:50 AM, the surveyor toured the 3rd Wing of the with staff and observed the following: 1. The surveyor entered Resident #35's room with a Certified Nurse Aide (CNA). Resident #35 was observed in bed resting. The CNA informed the resident of the task and the CNA proceeded to turn the resident over. The surveyor, along with the CNA observed that Resident #35 was soaked with urine and was wearing two incontinence briefs. The breakfast tray was noted on the bedside table that was untouched. On 02/08/23 at 9:10 AM, during an interview with the CNA, she stated that the facility was shorthanded. She further added that she did not check the resident for incontinence during her first round or resident checks. The CNA stated she knew that most of the residents were wearing two incontinent briefs. The CNA added, most of the time in the morning the residents would be soaked with urine and the bedding would also be soaked with urine. On 02/08/23 at 09:45 AM, the surveyor returned to the Resident #35's room and observed the breakfast tray was still on the table and was untouched. 2. On 02/08/2023 at 9:15 AM, the surveyor entered Resident # 57's room. The surveyor observed the resident was in bed. The resident's arms were folded and rested on the chest area. The lower extremities were contracted. The resident had his/her eyes open and was looking around. Resident #57 was being administered a tube feeding at that time. The CNA was present and put the feeding tube on hold, informed the resident of the task and proceeded to turn the resident. The surveyor observed that the bedding was wet, and Resident #57 was wearing two incontinent briefs. Resident #57's nails appeared jagged and were soiled with debris underneath all nail beds. The fingers were curled into the palm of both hands. There were no hand rolls in place. An interview with the CNA revealed that the facility had been shorthanded since the pandemic. The CNA stated when she first started back in 1994, she used to have 7 to 8 residents on her assignment. Gradually she was to care for 10 to 12 residents on the 7:00 AM- 3:00 PM shift. She stated lately she cared for 30 residents and only two CNA's were assigned. She stated the CNAs were unable to provide the care required by the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. At 9:30 AM the surveyor entered Resident #45's room with the CNA and observed the resident in bed. The resident was awake and alert and consented to be checked. The resident was wet and was wearing double incontinent briefs. The resident's nails were long and jagged. The CNA stated that only one CNA worked the night shift and could not provide incontinent care to all residents every two hours. The current Wing census was 29. 4. On 02/08/23 at 10:05 AM, the surveyor entered Resident # 59's room with the Licensed Practical Nurse (LPN). The surveyor observed the resident in bed, the head of the bed was elevated, the resident's eyes were closed. The LPN informed the resident of the task and proceeded to turn the resident. Resident #59 was soaked with urine and was wearing double incontinent briefs. On 02/08/23 at 10:31 AM, the surveyor left the room and interviewed the nurse regarding incontinent care. The nurse revealed that staff were to provide incontinent care every two hours, and as needed. When asked about the double briefs that were observed on residents during the surveyor observations, she stated that the CNAs had been educated several times regarding having double briefs on the residents. The LPN further stated that for infection control purpose, residents should not have double briefs on. 5. On 02/08/23 at 10:45 AM, the surveyor checked a random room on the 100's Wing. The surveyor knocked at the door and with permission, entered the room and observed two CNAs at the bedside of Resident #88. The CNA's informed the surveyor that they were about to provide care to the resident. At that time, the surveyor observed that Resident #88 was wearing double incontinent briefs, was soiled with feces and urine, and was also observed with a pressure sore. Both CNAs stated that they did not provide care yet to the resident and were not responsible for putting two incontinent briefs on the resident. Resident #88's nails were long, the fingers of the left hand were curled into the palm of the left hand and a dark film was underneath all of the nails. There was no hand roll in place. 6. On 02/08/23 at 11:46 AM, the surveyor observed Resident #1 seated in a wheelchair inside the room. The resident requested to speak with the surveyor. The resident stated that he/she had been at the facility for 8 years. Resident #1 stated that currently the facility was poorly managed, and the CNAs had attitudes. When asked to elaborate, he/she stated that he requested to get to bed by 9:00 PM daily. He/she met with the administrative staff and requested that this information be entered on the care plan to facilitate communication amongst staff. Resident #1 stated that this information was again discussed during the quarterly Interdisciplinary Team meeting. Almost daily he/she could not get to bed as requested. Staff would say they cannot accommodate his/her request due to the facility being shorthanded. The resident stated that he/she needed assistance with transfer and to use the bathroom. He/she followed a routine and needed assistance around 3:00 PM to use the bathroom daily. Resident #1 stated that some days he/she could not find any staff to assist. He could take between 45 minutes to 1 hour for staff to answer the call light. The resident stated that he fell and was on the floor for twenty minutes before someone answered the call light. The surveyor reviewed the resident's care plan and verified that the information regarding his/her preference for bedtime was entered on the care plan, and staff were to honor his/her preference or explain if the request would be delayed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/10/23 at 9:28 AM, the surveyor interviewed the registered nurse (RN) on the 3rd Wing. The staffing board at the nursing station indicated a census of 29 with 1 RN, and 2 CNAs. The RN explained that the staffing levels were split between the four wings and usually two CNAs were assigned on each wing. The RN stated they were short one CNA that day, and when asked about usual staffing she stated, they were short CNAs at all times. On 02/10/23 at 11:45 AM, the surveyor observed Resident #88 in bed with the head of the bed elevated. The lunch tray was placed in front of him/her and was set up with utensils to eat. Resident #88 was then left to feed herself/himself independently with no assistance offered. Resident #88 was observed as being unable to reach the meal tray. The surveyor left the room and escorted the RN, Unit Manager (RN/UM) to the room. The RN/UM confirmed that Resident #88 was not set up properly to eat. The UM repositioned the resident and exited the room. The surveyor observed when the meal tray had been removed, nothing had been touched. There was no staff to assist/ supervise Resident #88's intake or ability to feed himself/herself independently. A review of the Care Plan revealed that Resident #88 must be supervised at all meals. On 02/21/23 at 9:45 AM, the surveyor observed Resident #88 in bed. The breakfast tray was setup for the resident to eat. The resident attempted to drink the juice and was falling asleep. The breakfast tray was untouched and there was no one supervising the resident at mealtime. The surveyor informed the LPN who was seated at the nursing station that the resident was not eating. The LPN stated that she set up the tray, ensured that Resident #88 could reach the spoon and left the room. The LPN was not aware that Resident #88 required assistance and supervision with all meals per Resident #88's Care Plan. On 02/21/23 at 11:05 PM, the surveyor reviewed Resident #88's care plan which revealed Resident #88 was at nutritional risk due to dysphagia but still wants to eat by mouth. Staff were directed to Supervise/cue/assist as needed with meal. Resident #88 was to be assisted at mealtimes. On 02/21/23 at 11:53 AM, the surveyor interviewed the staffing Coordinator who stated that staffing was based on HPPD (hours per patient per day). The calculation was done by adding nurses and CNA hours and divided by the census. She was aware of the State regulation sets forth for the ratio of CNA to residents. She stated that since the pandemic[2020], staffing had been a challenge and the facility had not been able to meet the requirement. On 02/22/23 at 10:16 AM, surveyor #2, interviewed the Administrator (LNHA) regarding the staffing. The LNHA stated she was aware of staffing requirements. The LNHA stated that staffing was important to the facility and she had been made aware of the days that the facility did not meet the staffing minimums and would utilize other staff where she was able to. On 02/22/23 at 1:30 PM, the surveyor discussed the above concerns with the Director of Nursing (DON). The DON stated that she was aware of staff using two incontinent briefs on the residents and she had previously in serviced the staff. The DON acknowledged that staffing was a challenge. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Staffing/Center Plan, Effective 06/01/96, revealed the facility will provide qualified and appropriate staffing levels to meet the needs of the patient population. The staffing plan will include all shifts, seven days per week. Purpose: To assure that appropriate staffing levels are scheduled and maintained. Process: 1. The Center meets or exceeds the staffing levels mandated by state and federal staffing requirements., 2. Staffing levels are reviewed on an ongoing basis by center staff to evaluate compliance and provide appropriate levels of care by qualified employees., 4. The Center maintains appropriate staffing levels, with qualified personnel, 25 hours/day, seven days/ week on each shift to assure that patients are safe, and their needs are met. Inquiries concerning staffing should be referred to the Director of Nursing. Staffing inquiries for all other departments should be directed to the Center's Administrator . The Facility Assessment Tool, Updated 03/22/22 revealed Individual Staff Assignment, 3.3. Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments. Staff members have assignments that offer continuity of care throughout all disciplines. Staffing patterns are reviewed daily and adjusted to meet the needs of the patient population. This conversation is revisited throughout the day to ensure adjustments are made based on planned admissions. We strive for consistent staff- patient assignments by staff members regularly caring for residents on the same unit each day. NJAC 8:39-5.1(a); 27.1 (a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 42112 Based on interview and record review, it was determined that the facility failed to evaluate the performance of all Certified Nursing Assistants (CNAs) on an annual basis. This deficient practice occurred with 5 of the 5 CNAs whose personnel records were reviewed and was evidenced by the following: On 02/22/2023 at 12:40 PM, the surveyor reviewed the employee files of 5 randomly selected CNAs which were provided by the facility. The surveyor identified the following: CNA #1 had a hire date of 05/04/2015. According to the CNA #1's personnel record, the last documented performance appraisal was 09/22/2020. There were no annual performance reviews conducted within the past year. CNA #2 had a hire date of 02/27/1996. According to the CNA #2's personnel record, the last documented performance appraisal was 09/18/2020. There were no annual performance reviews conducted within the past year. CNA #3 had a hire date of 10/12/2010. According to the CNA #3's personnel record, the last documented performance appraisal was 09/18/2020. There were no annual performance reviews conducted within the past year. CNA #4 had a hire date of 01/23/1991. According to the CNA #4's personnel record, the last documented performance appraisal was 09/22/2020. There were no annual performance reviews conducted within the past year. CNA #5 had a hire date of 12/09/1991. According to the CNA #5's personnel record, the last documented performance appraisal was 09/22/2020. There were no annual performance reviews conducted within the past year. During an interview with the surveyor on 02/23/23 at 10:57 AM, the Licensed Nursing Home Administrator (LNHA) stated she had been employed at the facility since November 2021. The LNHA stated that the purpose of a performance appraisal was to provide feedback for someone over a period of time, by reviewing an employee's strengths, their goals, and ways to improve. The LNHA stated that performance appraisals should be done annually. The surveyor then showed the LNHA the personnel records of CNA #1, CNA #2, CNA #3, CNA #4, and CNA #5, and confirmed that their performance appraisals were not completed annually. The LNHA further stated that the prior Director of Nursing (DON) and the current Assistant Director of Nursing Infection Preventionist (ADON IP) were responsible for performance appraisals. During an interview with the surveyor on 02/23/2023 at 12:16 PM, the ADON IP stated that the prior DON kept information on all facility staff. The IP added that she was not sure where the information was kept. The ADON IP was unable to provide documented evidence of performance appraisals for the 5 CNA staff reviewed annually (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility policy titled, Performance Appraisal, with a revision date of 03/29/2021, indicated that managers will meet with their regular full-time, regular part-time, and regular casual employees at least annually to conduct a performance appraisal or have a performance-based conversation. In-service education will be provided based on the outcome of these reviews. NJAC 8:39-43.17(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 31654 Based on observation, interview and document review it was determine that the facility failed to provided meals at acceptable temperatures for 2 of 4 residents interviewed during a resident council meeting and for 4 of 4 items sampled during a test tray observation. The deficient practice was evidenced by the following: On 02/14/23 10:33 AM, a surveyor conducted a resident meeting with four residents, and 2 of 4 residents stated that the food served would sit on the meal trays too long and would then be cold because there were not enough Certified Nurse Aides to give out the meal trays. On 02/15/23 at 11:37 AM to 12:08 PM, the surveyor entered the kitchen and observed the tray line in progress for the lunch meal. The surveyor observed the tray line while next to a Dietary Staff worker (DS #1) who was opposite the Cook. The surveyor selected a hot dog, cheese pizza, puree hot dog and four ounces of milk from the tray line and posted menu. The food temperatures had been recorded by the [NAME] and reviewed by the surveyor which revealed: hot dog 194 degrees Fahrenheit (F), puree hot dog 187 degrees F, cheese pizza 189 degrees F. On 02/15/23 at 12:08 PM, the test tray was plated by the DS #1 and an insulated base that was stacked next to the trays was used to hold the plate and an insulate lid was place on top of the food. The test tray left the kitchen and arrived on unit three at 12:09 PM. The surveyor, along with the Food Service Director (FSD) awaited the trays to be passed. On 02/15/23 at 12:12 PM, the first meal tray was passed. On 02/15/23 at 12:16 PM, the surveyor inquired to the FSD what the standard for the cold and hot food should be when it reached the resident. The FSD stated the cold food should be between 41-45 degrees F, and the hot food should be between 150-160 F. On 02/15/23 at 12:30 PM, the last meal tray had been passed (18 minutes between the first and last tray passed) and the FSD and surveyor immediately tested the food temperatures which revealed: 1. Hot dog- surveyor: 121.2 F, FSD: 120, the FSD stated it should be higher; 2. Puree hot dog- surveyor: 117.8 F, FSD: 118 F; 3. Pizza- surveyor: 114 F, FSD: 112.2 F; 4. Four ounces milk- surveyor: 50.6 F, FSD: 49.5 F; On 02/15/23 at 12:34 PM, the surveyor asked if the amount of time it took to pass the meal trays was typical and the FSD stated usually doesn't take this long. The surveyor requested the policy for food temperatures. On 02/16/23 at 8:55 AM, the FSD provided the surveyor with a copy of a blank test tray log. The log revealed the Temperature Standard for Hot Foods was 150 F, and for Cold foods 45 F. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-17.4(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on observation, interview, and document review, it was determined that the facility failed to ensure a.) that the kitchen environment, equipment and resident meal service items were maintained in a clean and sanitary manner, b.) a walk in refrigeration unit maintained appropriate food temperatures, c.) a commercial dishwashing machine was operated within manufactures specifications, d.) food temperatures were consistently monitored, e.) hair restraints were consistently worn, and e.)food items were consistently labeled and dated with a use by date to limit the spread of infection and potential food borne illness. The deficient practice was evidenced by the following: On 02/08/23 at 8:51 AM through 9:25 AM, the surveyor conducted an initial tour of the kitchen. The surveyor observed the [NAME] wearing a surgical mask under his nose and facial hair was protruding out the side of his mask. The [NAME] was not wearing a facial restraint. There were two additional dietary workers in the kitchen who informed the surveyor that the Food Service Director (FSD) was on the way. The surveyor went to the large walk-in refrigerator unit with the [NAME] and asked the cook what the temperature of the unit was. The [NAME] proceeded to look at the external temperature gauge and the surveyor observed that the needle appeared broken. The thin indicator side of the temperature needle was not registering any temperature, was in the white area of the gauge, and below the temperature reading. The larger opposite side of the temperature needle appeared to be facing the green colored area between 35 to 40 degrees Fahrenheit (F). The cook then retrieved an internal thermometer and stated the temperature of the refrigerator was 37-38 (degrees F), the surveyor observed the thermometer reading at 42 degrees F and the [NAME] then asked the surveyor what the temperature was. The [NAME] then looked at the external thermometer, that appeared broken and stated the temperature was 37-38 (degrees F). At that time, the surveyor requested that the [NAME] take the internal temperature of a food item inside the refrigeration unit. The [NAME] stated, I don't have access to a thermometer, it's locked in office. At that time the cook was trying to find a key for the office. The surveyor asked the [NAME] if he had taken food temperatures for the breakfast meal that he cooked and he stated, today, no, because the thermometer was in the office and again stated, no, he did not take food temperatures. The surveyor then observed a refrigerator temperature log affixed on the outside of the refrigeration unit. The log was for February 2023, and the AM temperature on 02/08/23 was handwritten in, as 37, and was also initialed. On 02/08/23 at 9:01 AM, the FSD entered the kitchen, with a surgical mask over his face and facial hair was protruding out of the sides. At that time, the FSD and surveyor entered the walk-in refrigerator unit, and the surveyor observed a 1/4 sized metal pan on a shelf. The pan contained pieces of ham, identified by the FSD, and there was no label or use by date on the ham. At that time the surveyor asked the FSD what was worn to cover facial hair, and the FSD stated they wore beard guards. The surveyor asked the FSD if his facial hair was covered, and he confirmed it was not covered. The FSD and surveyor exited the refrigerator unit, and the surveyor observed a can opener affixed to a metal table, and the black can opener insert had visible debris affixed to it. The FSD stated it needed to be cleaned, and the surveyor asked if it was cleaned and the FSD stated technically no. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/08/23 at 9:07 AM the surveyor inquired to the FSD regarding if food temperatures should be taken when the food is cooked. The FSD stated yes that food temperatures should be done and stated yes the cook has to take them and use thermometers. The FSD stated there should have been a thermometer available there and supposed to be thermometers at the cooking station. The FSD stated he has been in the FSD position for four to five months and that he was employed by a management company, not the facility. 02/08/23 at 9:11 AM, the surveyor asked the FSD to take the temperature of an item that was inside the refrigerated walk-in unit. The FSD took a 4-ounce container of milk, that he removed from a crate, inserted his thermometer and the temperature was 41.2 degrees F. The FSD stated that the temperature should be below 41 degrees F. The FSD stated the milk was delivered yesterday, and then proceeded to take a 2nd 4-ounce milk from a different milk crate. The FSD inserted his thermometer, and the temperature was 47.8 degrees F. At that time, the surveyor asked the FSD what the temperature was for the refrigerated walk-in unit, and stated, he called the unit the produce box and looked at an internal thermometer which read 45 degrees F. The surveyor asked the FSD to check another food item, and the FSD removed a 6-ounce juice container and inserted his thermometer. The surveyor asked the FSD if the thermometer was calibrated, and he stated it was. The surveyor asked the FSD if the temperature was okay, after the FSD was looking at the thermometer inside of the juice. The FSD stated, no, not okay, and showed the surveyor that the thermometer was at 52 degrees F. At that time, the FSD stated to the surveyor that the food temperatures were not good, and both the FSD and surveyor observed that two logs were affixed next to both walk in refrigerator units and both were documented as 37 degrees F on 02/08/23. The surveyor asked the FSD if there had been any concerns regarding the walk-in refrigeration unit and the FSD stated he was not aware and he will follow- up. On 02/08/23 at 9:42 AM, the surveyor re-entered the kitchen and inquired to the FSD about the walk-in refrigeration unit temperature. The FSD stated that the maintenance person from the facility came and moved the temperature control for the walk-in refrigeration unit to a colder setting. The surveyor asked the FSD to check the temperature of an item. The FSD removed a 4-ounce milk container from a lower crate in the back of the walk-in refrigeration unit. The surveyor and FSD proceeded to take the temperature of the milk which was 43 degrees F. The FSD stated that the maintenance person was contacting the vendor to come look at the unit, and it was the first time that he had heard about the unit having an issue with temperature maintenance, and that both he and the maintenance person were unaware of any issues with the walk-in refrigeration unit until the surveyor brought it to his attention. On 02/08/23 at 9:49 AM, the surveyor observed a bread rack. There were five loaves of undated raisin bread on the rack. The FSD stated, they forgot to put dates on it. On 02/08/23 the LNHA provided the surveyor with a copy of an email dated 02/09/23 at 10:36 AM subject: walking repairs, which revealed: Called by building maintenance director at 10:00 AM on 02/08/23 stating walking refrigerator running warm, arrived 11:00 AM 02/08/23 and checked [NAME]. Walking #1 found at 50 degrees. Cleaned evaporator and condenser coils. Replaced the thermometer on walking box front panel. Door warped, added gasket material and will get pricing on new door and order. Walking #2 found at 42 degrees. Cleaned condenser coil. Replaced the thermometer on walking box front panel. Adjusted temperature setting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/08/23 at 12:58 PM, the surveyor interviewed the facility maintenance person, who stated he was not the maintenance director, along with a representative from the facility's corporate maintenance department (CMD). The CMD stated that the walk-in refrigeration unit needed to have the coils cleaned on the condenser and evaporator, and that usually the maintenance director would have been responsible to keep that clean because it would affect the temperature of the unit. The CMD also stated that the door to the walk-in refrigeration unit was warped, and that could also affect the temperature and that both external thermometers were broken, and he was going to replace both. On 02/08/23 at 1:40 PM, the surveyor entered the kitchen to inquire about the walk-in refrigeration unit. A District Manager (DM) from the food service management company was in the kitchen. The surveyor asked about the temperature of the unit and the DM went to the unit and the surveyor asked the DM to take the temperature of a food item. The DM removed a 4-ounce container of milk, took the temperature of the item which was 41.9 degrees F. The surveyor asked if the DM had checked the temperature of the food prior to surveyor inquiry and the DM stated, the maintenance people are still working on the unit, and the surveyor observed multiple stacked crates of milk, and other food items inside the unit as in the prior observations. The DM stated that he checked a food item one hour ago at 12:30 PM, and the item (undisclosed) was 42 degrees F. The DM stated that food should be below 41 degrees. At that time the surveyor asked the DM to accompany the surveyor to the facility Administrator's office (LNHA) and the surveyor advised the LNHA, in the presence of the Corporate Nurse (CN), of the temperature concerns and issues conveyed by the CMD. Both the LNHA and CN were unaware of the temperature concerns regarding the walk-in refrigeration unit. On 02/15/23 at 11:38 AM to 128 PM, the surveyor entered the kitchen and observed the tray line in progress for the lunch meal. The surveyor observed a differed food service management company district manager in the kitchen. The surveyor observed the tray line while next to a Dietary Staff worker (DS #1) who was opposite the [NAME] and was at the tray line start position and prepared the 4th Wing trays. On 02/15/23 at 11:46 AM, the DS was observed removing meal trays that were stacked on the tray line and that were visibly wet. The DS then used a napkin to dry the trays as she set them up with resident meal tickets and food items. At that time, the FSD was also in the kitchen and the surveyor inquired as to the drying process for the meal trays. The surveyor pointed to the wet trays and the FSD stated that the facility had a low temperature dish machine, so they used a fan to dry the trays. At that time, the surveyor observed a large box type fan suspended from the ceiling and was aimed toward the exit area of the dish machine. On 02/15/23 at 11:54 AM, the surveyor observed the DS take a napkin with her gloved hand and wipe the wet trays, the DS then reused the napkin which was visibly wet and continued to wipe the trays and set them up with resident's meals. The surveyor asked the FSD about the DS process of wiping the trays with a napkin and the FSD stated, no, she is not supposed to be doing that, trays should be dry, then took a different type of towel and proceeded to wipe the trays. The surveyor observed 24 wet trays in total that were wiped with a napkin by the DS. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/16/23 at 9:37 AM, the surveyor entered the kitchen and observed the commercial dish machine (machine) was being set up to clean the breakfast dishes. The surveyor observed that the large box fan that was suspended above the exit area of the machine was turned on. There were fourteen clean meal trays in a rack, placed in front of the blowing fan. The fan was visibly covered with dark dust like particles throughout the grate of the fan. At that time the surveyor inquired to the FSD what the fan was doing. The FSD stated we don't have a rack for the trays, the fan is to help air dry the trays. The surveyor asked the FSD if the fan was clean, and the FSD stated it is dusty. The surveyor requested an equipment policy at that time. On 02/16/23 at 9:47 AM, the surveyor observed a four-tier metal rack base with four metal racks, that had embedded dark greasy areas throughout the rack edges, and crumb like food particles. The four racks were removable and were used to hold insulated tray items as confirmed by the FSD. The surveyor showed the FSD the crumb like and greasy areas and asked the FSD if the rack was cleaned. The FSD stated monthly or as needed. A rack of clean pots, adjacent to the four-tiered rack had copious types of food type crumbs and debris underneath on the floor, and the surveyor asked the FSD if the floor is cleaned. The FSD stated maybe they missed it. 02/16/23 at 9:51 AM, the surveyor observed DS #2 placing dishes and other items through the dish machine for cleaning. The surveyor asked the DS #2 what the temperature of the machine was. The DS #2 stated the hot was 160 degrees F and the rinse was 170 degrees F. The FSD interjected and stated that the wash was 140 degrees F, and the rinse was 150 degrees F, and stated the machine was a low temperature machine, not a high temperature. On 02/16/23 at 9:55 AM, the surveyor, in the presence of the FSD, observed that the DS #2 was running items through the dish machine and observed the wash gauge was 150 degrees F and the rinse gauge was 135. At that time, the FSD stated there was an issue with the dish machine and told the surveyor that the thermostat for the dish machine was broken and needed to be replaced. The surveyor asked the FSD how the dish machine would then be checked to ensure it was effectively sanitizing the dishes if the thermostat was broken. On 02/16/23 at 9:56 AM, the FSD stated there was an issue with the dish machine and that the repair company came to look at it and determined there was an issue with the rinse thermometer. The FSD stated there was an email that documented the concern, and the surveyor requested the email. On 02/16/23 at 9:57 AM, the surveyor asked the FSD how the dish machine would be checked and the FSD showed the surveyor the sanitation test strips (strip) to measure the amount of chemical sanitizer in the dish machine. The FSD took a test strip and placed it between two cups and ran the cups through the dish machine. At that time the FSD stated the strip should read 50 parts per million (PPM) which was a dark charcoal color per the test strip bottle. Once the strip exited the machine, the FSD showed the surveyor the strip next to the indicator color on the strip bottle. The strip was a very light gray color which matched the 10 PPM color on the bottle and the FSD confirmed it was not the proper concentration at 50 PPM. The FSD then attempted a second placement of a strip and ran the strip through the dish machine. The FSD then removed the strip and placed it next to the test strip bottle. The strip appeared the same light color as the previous strip and matched the 10 PPM color. The surveyor asked the FSD if the strip matched the 10 PPM light gray and he stated, I believe so. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/16/23 at 10:04 AM, the FSD run another strip through the dish machine and showed surveyor color of strip which matched the light gray color at 10 PPM. The FSD then stated, at this point I am going to not use the machine until I figure what is going on and he instructed his staff that they are going to use the three compartment sink to finish the dishes. He was unable to confirm that the machine worked appropriately after multiple attempts to check the sanitation concentration which did not meet the required 50 PPM. During the dish machine observations, the surveyor observed the ceiling tiles above the dish machine area were visibly soiled with dark colored debris and fuzz like matter and were also over the area where the clean dishes were stored. The surveyor asked if the ceiling tiles were cleaned, and he stated they had been cleaned once by maintenance since he had worked there. On 02/16/23 at 10:59 AM, the surveyor reviewed the dish machine sanitation log for that day. The surveyor observed the log was dated for February 16, 2023, and the Breakfast Wash temperature was 140 degrees, the Rinse temperature was 156 degrees, and the PPM was 50 and it was illegibly initialed. The surveyor interviewed DS #1 and DS#2 who denied documenting the temperatures and PPM. DS #3 stated she took the temperatures and stated she read them from the machine at 8:00 AM. The surveyor asked DS #3 about the PPM 50 number and showed her the bottle of the test strips and asked her if she had used the test strips to get the number. The DS #3 stated she didn't know anything about the bottle of the test strips that the surveyor was holding and stated that she had copied the 50 number from the previous number. The surveyor asked DS #3 if she had been trained on uses the test strips and she stated no. The surveyor asked the FSD regarding if he had trained the DS #3 and he confirmed that he had not trained her to use the strips. The surveyor asked DS #3 if she had been aware of a broken temperature gauge on the dish machine and she stated no. On 02/16/23 at 11:57 AM, the surveyor interviewed the dish machine repair company representative (RPR) who stated he was called in today to check the dish machine. The RPR stated the thermostat for the machine needed to be replaced and he was called in the day before by the FSD. The RPR stated he came last night, and the sanitizer was working on the dish machine, and he checked the temperature with his thermometer and the machine had been okay. The RPR stated that he was contacted today and informed that the dish machine was reading 10 PPM on the sanitizer. The RPR stated he came today and increased the amount of sanitizing chemical the machine was dispensing. He then showed the surveyor a dark charcoal colored test strip that matched the 50 PPM and stated he also calibrated the dish machine chemical sanitizer and stated the bottle of chemical sanitizer for the dish machine was not connected to the dish machine appropriately and was very low when he had come today. The RPR stated that because chemical was not appropriately connected to the dish machine it was not drawing up the proper amount of chemical that was required and stated that when he had left last night it was working appropriately. He stated that the dish machine was being operated as a low temperature machine because the heat booster had not been functioning and needed to be replaced. The RPR stated it was important to have the proper chemical concentration and stated you needed that for safety purposes. The surveyor reviewed the following policies which revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Warewashing Policy, Revised 09/2017 revealed that all cookware, dishware, and serviceware will be cleaned and sanitized after each use., Procedures: 1. The Dining Services staff will be knowledgeable in the proper technique for processing dirty dishware through the dish machine, and proper handling of sanitized dishware. 2. All dish machine water temperatures will be maintained in accordance with manufacturer recommendations for high temperature or low temperature machines. 3. Temperature and/or sanitizer concentration logs will be completed, as appropriate. 4. All dishware will be air dried and properly stored. Staff Attire, Revised 09/2017, All employees were approved attire for the performance of their duties., Procedures: 1. All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. Receiving, Revised 09/2017, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items., 5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. A Food Storage and Retention Guide, Refrigerator less than or equal to 41 degrees F for dairy items. Food Preparation, Revised 09/2017, All foods are prepared in accordance with the FDA Food Code., 1. Staff will practice proper hand washing and glove use., 3. All utensils, food contact equipment, and food contact surfaces will be cleaned and sanitize after every use., 10. Time/Temperature Control for Safety (TCS) hot food items will be cooked to a minimum internal temperature for 15 seconds, as follows: Poultry and stuffed foods 165 degrees F, Ground meat 155 degrees F, Fish, pork, other meats, 145 degrees F, Unpasteurized eggs 145 degrees F., 13. Temperature for TCS foods will be recorded at time of service, and monitored periodically during meal service periods. Food Storage: Cold Foods, Revised 4/2018, All Time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code. Procedures: 2. All perishable foods will be maintained at a temperature meeting safe food handling standards., 4. An accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures will be recorded. If corrective action is necessary, designated staff members will monitor temperatures until food storage environment is acceptable., 5. All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. Facility provided dish machine specifications revealed: Chemical Sanitizer Rinse, Minimum chlorine PPM (low temp), 50 PPM Environment: Revised 09/2017, All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition., 1. The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 2. The Dining Services Director will ensure that all employees are knowledgeable in the proper procedures for cleaning and sanitizing of all food service equipment and surfaces., 4. The Dining Services Director will ensure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces. NJAC 8:39-17.2(g)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 38079 Based on observations, interview, review of medical records and review of facility documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure: a.) that policies and procedures were developed and implemented to mitigate the spread of infections, and b.) documented on-going staff education and in-services were completed to combat breaks in infection control practices. The multiple observed breaches in infection control practices by multiple facility disciplines, were identified on 02/08/23, 02/09/23, and 02/10/23 on 4 of 4 resident care Wings. This posed a serious and immediate threat to the health, safety and well-being of all residents who resided at the facility due to the lack of infection control oversight provided by the LNHA, which resulted in an Immediate Jeopardy (IJ) that began on 02/08/23 and was identified on 02/10/23 at 4:07 PM. The LNHA was notified of the IJ situation on 02/10/23 at 4:08 PM. The failure of the LNHA to ensure the facility operated in a manner that ensured residents were cared for and an environment that enabled residents to maintain or attain their highest practicable physical, mental, and psychosocial well-being posed a serious and immediate threat to the health, safety, and welfare of staff and all residents who resided at the facility in compliance with federal, state and local requirements as outlined in the Center Executive Director Job Description,. A removal plan was accepted on 02/13/23 at 10:17 AM. The survey team verified the removal plan on 02/13/23 at 12:33 PM. A review of the facility's Center Executive Director Job Description provided on 02/10/23, included but was not limited to the following; Position Summary: The Center Executive Director is responsible for planning and is accountable for all activities and departments of the Center subject to rules and regulations promulgated by government agencies to ensure proper health care services to residents. The Center Executive Director administers, directs, and coordinates all activities of the Center to assure that the highest degree of quality of care is consistently provided to residents. Works in close collaboration with the Center Nurse Executive to assure high quality clinical outcomes. Ensures staff participate in orientation and training programs .relative policies and procedures, and that such training is properly documented. Refer to: F880, F886 Findings include: On 02/08/23 at 11:12 AM during entrance conference, the LNHA stated the facility was currently in a COVID-19 outbreak. The outbreak began 10/23/22, and the facility currently had 27 COVID-19 residents on four of the four resident care Wings. The survey team requested multiple documents, one of which was the facility staff in-service and education information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23, during tour of the facility, the survey team observed isolation transmission-based precaution (TBP) resident rooms on 4 of the 4 resident care Wings. The surveyor observed Resident #31's room on the 2nd wing. Resident #31's room did not have any TBP signage affixed to the resident's door, or Personal Protective Equipment (PPE) containers outside the room and readily available. The surveyor observed Resident #88's room on the 1st wing. Resident #88's room did not have any TBP signage affixed to the resident's door, or PPE containers outside the room and readily available. The surveyor conducted medical record reviews which included, but were not limited to, Resident #31 had a physician's order dated 12/08/22 to be placed on contact precautions (procedures that reduce the risk of the spread of infections through direct or indirect contact) for Extended spectrum beta-lactamases (ESBL - an organism which is among those responsible for antibiotic resistant strains) of the urine every shift. Resident #88 had a physician's order dated 01/04/23 to be placed on contact precautions for Methicillin-resistant Staphylococcus aureus (MRSA - a cause of staph infection that is difficult to treat because of resistance to some antibiotics) of the sacral wound every shift. On 02/08/23 at 10:58 AM on the 1st wing, Surveyor #1 and #2 observed a laundry aide walking down the hall wearing a PPE gown which was not secured in the back, an N95 mask and eye protection. The laundry aide entered a COVID-19 positive resident room and through an open door, the surveyors observed her touched multiple environmental surfaces, including the furniture. The laundry aide exited the room without first removing her gloves and perform hand hygiene. On 02/10/23 at 9:28 AM in the presence of three surveyors, the LNHA, Director of Nursing (DON), and Assistant Director of Nursing Infection Preventionist (ADON IP) were interviewed and made aware of the situation concerning the two residents who had not been placed on TBP as per physician's orders. The LNHA, DON, and ADON IP acknowledged they were not aware of the two residents being on TBP and that there was no signage affixed to the resident's room doors to alert staff of the required PPE to wear to protect themselves and other residents. The ADON IP stated the facility kept an antibiotic listing but, infections were not tracked for every patient unless an antibiotic was ordered. The LNHA was not aware of no documented tracking of residents on TBP despite an ordered antibiotic. On 02/10/23 at 12:58 PM, the survey team asked the LNHA a second time for the staff education book. The LNHA stated, I thought I told you I gave you all the education I had to give. When asked if the few in-services she gave encompassed the entire staff, the LNHA stated she was not sure and I guess I can have nursing give you the book to see. On 02/10/23 at 1:23 PM, the ADON IP and Registered Nurse (RN) in training for IP, were being interviewed. The ADON IP stated in-services and education for the staff on Infection Control was done, on and off and whenever I get a chance. She further stated that there were not always sign in sheets kept to document who attended or the content of education or in-services. The LNHA was not aware of the lack of completed, documented education, in-services, and competencies for the facility staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/10/2023 at 10:49 AM on Wing 4 of the facility, a surveyor observed a housekeeper wearing an N95 mask and a face shield. The housekeeper was observed in the doorway of a COVID-19 positive resident room which had signage on the door to indicate what the TBP was and what PPE was required. The housekeeper had not donned a PPE gown or gloves. The housekeeper was using his bare hands to tie a plastic bag that contained used, soiled PPE gowns. The housekeeper then brought the plastic bag filled with soiled PPE gowns out into the hallway and placed the bag on top of the housekeeping cart. The surveyor asked the housekeeper what the process was for collecting soiled gowns in resident rooms that were on droplet precautions or any transmission-based precautions (TBP)? The housekeeper stated that he followed directions from his administrator (LNHA). On 02/10/23 at 2:27 PM, the LNHA and DON were being interviewed. The surveyor asked who was responsible for overseeing the Infection Control program? The DON stated she and the LNHA were responsible. The LNHA was present and agreed. On 02/22/23 at 10:00 AM the LNHA was interviewed in the presence of the survey team. regarding her job decription. The surveyor asked if the LNHA was responsible for everyong in the facility and she stated, ultimately yes and the surveyor inquried if that included infection control and the LNHA stated yes. The surveyor asked what her role in infection control was, the LNHA stated to make sure we have an infection preventionist. On 02/22/23 at 10:04 AM, the surveyor asked if the LNHA was aware that there was no one assuming the ADON IP's role when she had been out. The LNHA sated it would have then deferred to the DON. When asked if the LNHA was aware that all COVID-19 testing was not completed as indicated. The LNHA stated honestly, not. The surveyor asked the LNHA if she should have been made aware and she staetd absolutely, things should have been communicated to me so I could have strategized. A review of the facility provided, Outbreak Investigation / Management policy and process revised 02/01/23, included, but was not limited to 6. Notify: 6.1. Administrator 7. Implement control measures based on signs, symptoms, diagnosis, mode of transmission, and location in the Center. 8. Conduct staff education/competencies as needed regarding disease outbreak and mode of transmission. 10. Monitor for effectiveness of investigation and control measures until cases cease to occur or return to usual levels. The LNHA failed to ensure these directives were being followed. A review of the facility provided, Infection Control Policies and Procedures for COVID-19, effective 03/27/20 and revised 12/07/22. The Policy revealed: General Standard Precautions: 9. Follow CDC published guidance related to the use of facemasks, respirators, gowns, gloves, and eye protection. Education: 31. Provide COVID-19 education as indicated to employees, patients, and visitors. The LNHA failed to ensure these directives were being followed. NJAC 8:39- 19.1(a); 19.2(a)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Part A Based on observation, interview, record review and review of pertinent documentation, it was determined that the facility, who has been in an active COVID-19 outbreak status since 10/23/22, failed to ensure: a.) a system was in place and followed to prevent the spread of multidrug resistant infections (organisms resistant to multiple antibiotic treatments including Methicillin Resistant Staph Aureus [MRSA], extended spectrum beta-lactamase [ESBL], vancomycin resistant enterococcus [VRE]) and COVID-19 (a deadly virus), and b.) facility policies and current infection control guidance was followed to limit the spread of infection. The breaches in infection control practices were observed by the survey team on 02/08/23, 02/09/23, and 02/10/23, for 4 of 4 Resident Wings and was evidenced by the following: Reference: Centers for Medicare and Medicaid Services Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH DATE: August 26, 2020 REVISED 09/23/2022. Centers for Disease Control and Prevention, COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022. The facility's system wide failure to ensure that infection control practices were implemented to mitigate the spread of MRSA, ESBL, VRE, and COVID-19 posed a serious and immediate risk to the health, safety and well-being of all residents who resided at the facility. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that began on 02/08/23 and was identified by the survey team on 02/10/23 at 4:07 PM. The Administrator was notified of the IJ on 02/10/23 at 4:08 PM A removal plan was accepted on 02/13/23 at 10:17 AM. The survey team verified the removal plan on 02/13/23 at 12:33 PM. On 02/08/23 at 9:08 AM during tour of the facility, surveyor #1 observed Resident #31's room on the 2nd Wing. Resident #31's room did not have any transmission-based precaution (TBP) signage, or PPE (personal protective equipment, including gowns, gloves, etc.) containers outside of the room and readily available. Surveyor #1, entered the room and attempted to interview Resident #31 at that time and the resident was confused and unable to be interviewed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/02/23 at 10:00 AM, surveyor #1 returned to Resident #31's with a Certified Nursing Assistant (CNA) to perform an incontinence check. There was no PPE signage, or PPE available at the resident's room at that time. The surveyor entered the room with the CNA. The CNA was wearing an N95 respirator mask (filters out 95% of airborne particles), eye protection and gloves, and proceeded to re-position the resident, who was awake, and then check the resident's incontinence brief (disposable brief designed to collect urine and feces). The CNA completed the entire task without wearing a PPE gown. Surveyor #1 reviewed the medical record for Resident #31. Resident #31 was admitted to the facility with diagnoses which included but were not limited; to urinary tract infection and sepsis. A review of the most recent Quarterly Minimum Data Set (MDS), an assessment tool dated 11/21/22, revealed Resident #31 required extensive assistance of at least one staff for toileting; was always incontinent of bladder and bowel and did not have any urinary or bowel appliances. A review of a physician's order dated 12/08/22, revealed the resident was ordered to be placed on contact precautions (procedures that reduce the risk of spread of infections through direct or indirect contact) for ESBL of the urine every shift. A review of the facility provided urinalysis with a culture and sensitivity test, Lab Results reported 12/02/22, revealed organism identification to include ESBL. A review of the Medication Administration Report (MAR) for December 2022 revealed Contact Precaution due to ESBL in urine, with a start date of 12/08/22. There was no end date documented for the order, and staff were signing off as administered / completed from 12/08/22 through 12/31/22. A review of the MAR for January 2023 revealed Contact Precaution due to ESBL in urine, with a start date of 12/08/22. There was no end date documented for the order, and staff were signing off as administered/completed from 01/01/23 through 01/31/23. A review of the MAR for February 2023 revealed Contact Precaution due to ESBL in urine, with a start date of 12/08/22. There was no end date documented for the order, and staff were signing off as administered/completed from 02/01/23 through 02/10/23, when the MAR was printed. A review of the on-going resident Care Plan (CP) including resolved areas, revealed no focus area, goal or interventions for or related to contact precautions and/or ESBL of the urine. On 02/08/23 during tour of the facility, Surveyor #1, #2, and #3 observed Resident #88's room which was located on the 1st Wing. Resident #88 did not have TBP signage or PPE readily available outside the resident's room. A review of Resident #88's medical record revealed a physician's order dated 01/04/23 to be placed on contact precautions for Methicillin-resistant Staphylococcus Aureus (MRSA - a cause of staph infection that is difficult to treat because of resistance to some antibiotics) of the sacral wound every shift. On 02/08/23 at 8:40 AM on the 4th Wing, Surveyor #3 observed a Registered Nurse (RN) entering a COVID-19 positive resident room. The RN was wearing only an N95 (a respirator mask that filters 95% of airborne particles) mask and eye protection. The COVID-19 positive room had signage posted on the door which indicated what the TBP were and what PPE was required to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included, but was not limited to, performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The RN failed to follow the posted guidance and don (put on) a PPE gown or gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23 at 9:15 AM on the 2nd Wing, Surveyor #1 observed CNA #1 who was wearing an N95 mask and eye protection. CNA #1 donned a PPE gown, but failed to secure the back of the gown, and failed to don gloves. CNA #1 proceeded to pick up a meal tray and then entered a COVID-19 positive resident room. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE needed to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to; performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. Surveyor #1 also observed CNA #2 wearing an N95 mask and eye protection. CNA #2 picked up a PPE gown and entered the same COVID-19 resident positive room without first donning the PPE gown as indicated by signage. On 02/08/23 at 9:20 AM, Surveyor #1 observed the Director of Nursing (DON) on the 2nd Wing. During an interview at the time, the DON stated the staff should put all the required PPE on before entering a room. She stated the PPE gown needed to be secured in the back to keep the person protected, and that once someone entered a TBP room, they would be considered dirty. The DON stated she would send the Assistant Director of Nursing Infection Preventionist (ADON IP) over. On 02/08/23 at 9:28 AM, the ADON IP and the RN in training for IP arrived on the 2nd Wing. Both were made aware of the surveyor's observations. The surveyor observed both were wearing N95 masks and eye protection. The ADON IP stated staff must put the required PPE on outside of the TBP room and then tie the PPE gown in the back for protection. At that time, Surveyor #1 observed the ADON IP enter the same COVID-19 positive resident room without wearing a PPE gown or gloves. The COVID-19 positive room had signage affixed to the door which indicated what the TBP was and what PPE was required to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. On 02/08/23 at 9:37 AM, CNA #2 exited the 2nd Wing COVID-19 positive resident room and was interviewed by Surveyor #1 at that time. CNA #2 stated she had worked at the facility for [AGE] years and had been educated on PPE. CNA #2 stated she thought she was in the way, so she stepped inside the room to don her PPE gown. CNA #2 stated should not have entered the room without first putting on the PPE in order to protect herself and the residents. On 02/08/23 at 9:39 AM, CNA #1 exited the 2nd Wing COVID-19 positive resident room and was interviewed by Surveyor #1. CNA #1 stated she had worked at the facility for [AGE] years and had received training on PPE. CNA #1 stated she should have been wearing gloves, and that the PPE gown should have been tied in the back, but sometimes the ties become loose. Surveyor #1 asked what the process would be in the PPE gown became loose while in a TBP room. CNA #1 stated she should put her PPE gown in the hamper and then get a new one. On 02/08/23 at 9:50 AM on the 3rd Wing, Surveyor #3 observed the RN training for IP in the hallway. The RN donned gloves to pick up trash from the floor and then disposed of the trash. She then removed the gloves and touched a resident meal tray and had not performed hand hygiene or changed gloves. Surveyor #3 approached the RN training for IP and interviewed her. The RN stated, I probably should not have touched his/her tray. The RN then used the ABHR located in the hallway to sanitize her hands. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23 at 10:28 AM on the 1st Wing, Surveyor #2 observed CNA #3 exit a COVID-19 positive room wearing gloves and an N95 mask which had been positioned down on her face not and was not fully covering her nose. The COVID-19 positive resident room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. CNA #3 was carrying a meal tray that was not bagged and proceeded to place the meal tray directly on top of the shredder bin that was located in front of the nurse's station in the common area accessible to all nursing wings, and where residents were gathered. CNA #3 was observed moving the N95 mask up on her face multiple times. During an interview at that time, CNA #3 stated to the surveyor that normally she would have taken off her gloves, and that she had been fit tested for her N95 mask, but that it kept sliding down on her face. CNA #3 further stated there were no meal tray trucks, so she placed the meal tray on the shredder box. At 10:33 AM, Surveyor #2 observed CNA #3 enter the staff bathroom to wash her hands. CNA #3 turned on the water, applied soap and lathered her hands for 10 seconds with her hands under the running water. During an interview at that time, CNA #3 stated to the surveyor that the process was to lather her hands for 20 seconds. On 02/08/23 at 10:58 AM on the 1st wing, Surveyor #1 and #2 observed a laundry aide while she was walking down the hall and wearing a PPE gown which was not secured in the back, an N95 mask and eye protection. The laundry aide then entered a COVID-19 positive resident room and through an open door, the surveyors observed her touch multiple environmental surfaces including a dresser, and folded clothes, and proceeded to go to the other side of the room and touch other surfaces, including the furniture. She exited the room without first removing gloves, and performing hand hygiene. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to; performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The laundry aide did not perform hand hygiene upon exiting the room and proceeded to continue to wear the same gloves as she walked to the hallway of Wing #1. During an interview at that time, the laundry aide stated she had worked at the facility for [AGE] years and had been educated on PPE. The laundry aide confirmed it was her practice to wear the PPE gown through the hallway and stated the PPE gown should be tied in the back for protection. The laundry aide stated, Sorry I forgot when asked about if she should have been wearing gloves through the hallway. On 02/08/23 at 11:12 AM, during the entrance conference conducted with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the survey team was informed that the facility was currently experiencing a COVID-19 outbreak and there were 27 COVID-19 positive residents. The facility provided line list verified the COVID-19 outbreak began on 10/23/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23 at 12:25 PM on the 2nd wing, Surveyor #1 observed a recreation aide wearing an N95 mask, eye protection and a PPE gown. The recreation aide entered a COVID-19 positive resident room (Resident #95) without wearing gloves and was carrying a lunch meal tray. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The recreation aide placed the meal tray on the resident's over bed table and then moved the over bed table towards the resident with her bare hands. At 1:08 PM, the recreation aide exited the room and was interviewed by Surveyor #1. She stated she had worked at the facility for [AGE] years and had been educated on PPE and COVID-19. She further stated, I didn't see gloves. It was my mistake, sorry. On 02/09/23 at 9:08 AM, Surveyor #1 observed Resident #31's room and there was no TBP signage or PPE readily available. At that time the surveyor reviewed the medical record for Resident #31 which revealed an order dated 12/08/22 for contact precaution for ESBL of the urine. On 02/09/23 at 9:13 AM on the 3rd Wing, Surveyor #3 observed RN #2 wearing an N95 mask and eye protection. RN #2 donned a PPE gown and gloves and entered a COVID-19 positive resident room. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was required to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. RN #2 then exited the COVID-19 positive resident room wearing the same PPE gown which was not removed prior to exiting the room. On 02/09/23 at 11:39 AM, during an interview with Surveyor #1 and #2, the DON, in the presence of the LNHA, stated the facility had completed infection control audits and staff was educated to mitigate the spread of infection. The surveyors inquired to the DON for any documentation regarding the audits and education. The DON was unable to provide documentation and stated that the facility recently implemented a form that was used for audits, and the DON stated I don't know if they are always using it [form]. On 02/09/23 at 11:43 AM, the ADON IP stated she had been in contact with the Local Health Department (LHD) either, today, yesterday or the other day. She stated that the LHD had provided her with the Communicable Disease Services (CDS), COVID-19 Patient/Resident Management in Post-acute Care Settings guidance dated 01/23/23. On 02/09/23 at 12:30 PM, Surveyor #3 observed a resident who had tested positive for COVID-19 and was seated in the facility Atrium at a table. The surveyor went to the 3rd Wing to verify that resident was the COVID-19 positive resident who was on TBP. The resident's room door was observed open. Staff were not aware that the resident had left the room and was seated in the Atrium waiting for the lunch tray. The RN in training for IP observed the resident in the Atrium and then escorted the resident back to the unit. While being escorted to his/her room, Surveyor #3 heard the resident coughing. The staff confirmed that the resident was symptomatic and had been complaining of a headache also. During a subsequent surveyor interview, the RN in training for IP did not know or was not aware that the table the COVID-19 positive resident was sitting at, needed to be disinfected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/10/23 at 7:43 A.M. to through 8:22 A.M. on the 2nd Wing, Surveyor #1 observed a Registered Nurse (RN) #1 during a medication administration and observed the following: RN #1 walked up and down the 2nd Wing, administered medications to five residents and was within arm's length of the residents. The RN wore her eye protection on the top of her head offering no eye or face coverage or protection during her medication administration. At 8:22 AM, during an interview with Surveyor #1, RN #1 stated eye protection should be worn down over the eyes for protection. On 02/10/23 at 8:36 AM, RN #1 entered Resident #31's room. RN #1 was wearing an N95 mask and eye protection. RN #1 then picked up a pillow from floor with gloves on, helped the resident take a sip of their protein drink by touching the resident's head and environment, and then administered medications. RN #1 was not wearing a PPE gown and there was no TBP signage on the door. Surveyor #1 had conducted a medical record review on 02/09/23, for Resident #31 and there was a physician's order for contact precautions to be observed. On 02/10/23 at 9:28 AM in the presence of three surveyors, the LNHA, DON, and ADON IP were interviewed in the conference room. The DON stated there were no TBP residents other than COVID-19 positive on the 1st wing, 2nd wing, or 3rd wing. The DON stated there were only two residents located on the 4th wing with TBP other than COVID-19. The DON further stated that someone would let her know if there was an abnormal test result requiring TBP that she was not aware of. The DON stated that the staff would talk in clinical meeting and the physician would decide what TBP to order. After that, it would be the ADON IP's responsibility to put the signage up or have the nurse on the unit place the signage on the door. The DON stated the information would be communicated in the shift to shift report. The ADON IP stated nurses give report to other nurses and CNAs and that would be how the staff would know about TBP. The DON stated that contact precaution would require a PPE gown, gloves, N95 mask and eye protection; and that enhanced barrier and droplet precautions required everything PPE. The ADON IP stated the facility kept an antibiotic listing but, infections were not tracked for every patient unless an antibiotic was ordered. A review of the facility provided list, Resident's on precaution other than COVID-19 undated, but provided on 02/10/23, revealed two residents and their room numbers. The surveyor team identified that the first resident noted was on contact precautions for clostridium difficile (C diff - a contagious bacterium), and the second resident noted was on contact precautions for C diff, and VRE. Resident #31 and Resident #88 were not included on the facility provided list as the DON, ADON IIP, and LNHA were not aware of the physician ordered contact precautions for MRSA and ESBL. On 02/10/23 at 9:58 AM, Surveyor #1 interviewed RN #1 who stated there were no residents that required contact precautions on the 2nd Wing. RN #1 stated she would know that information because there would be signs posted on the door and the ADON IP would have put up the signs. On 02/10/23 at 9:59 AM, CNA #5 stated to the surveyor that there were no other residents on TBP besides COVID-19 on the 2nd wing. She further stated that if there were any other residents requiring TBP, the nurse would let the CNAs know during report and there would be a sign on the door also. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/10/2023 at 10:49 AM on Wing 4 of the facility, Surveyor #4 observed a housekeeper wearing an N95 mask and a face shield. The housekeeper was observed to don a PPE gown and gloves, enter a resident room, picking up soiled gowns and collecting soiled gowns in a see-through plastic bag. The housekeeper doffed (removed) his PPE gown and gloves inside the resident room, brought the bag with soiled PPE out into a cart in the hall and next sanitized his hands. The housekeeper was next observed in the doorway of a COVID-19 positive resident room wearing an N95 mask and face shield. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to; performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The housekeeper had not donned a PPE gown or gloves. The housekeeper was using his bare hands to tie a plastic bag that contained used, soiled PPE gowns. The housekeeper then brought the plastic bag filled with soiled PPE gowns out into the hallway and placed the bag on top of the housekeeping cart. Surveyor #4 asked the housekeeper what the process was for collecting soiled gowns in resident rooms for residents were on droplet precautions or any transmission-based precautions (TBP)? The housekeeper stated that he followed directions from his administrator. The housekeeper was unwilling to answer any additional questions from the surveyor and stated, please let me get back to work and do my job. On 02/10/23 at 11:30 AM, Surveyor #3 observed CNA #4 in the 3rd Wing hallway. CNA #4 reached inside a TBP room and picked up the breakfast meal tray without donning gloves. On 02/10/23 at 11:35 AM, Surveyor #3 observed a breakfast meal tray bagged and placed on the 4th Wing hallway shredder. Surveyor #3 read the name and verified the tray came from an isolation TBP resident room. On 02/10/23 at 12:02 PM, Surveyor #4 asked the LNHA what the process was for collecting used or soiled gowns from COVID-19 positive resident rooms and other TBP resident rooms. The LNHA stated that she would have to check what the process was and would provide the surveyor with the policy. On 02/10/23 at 2:00 PM, the LNHA provided the surveyor with a policy on the laundry process for collecting biohazard laundry. A review of the policy titled, The Laundry Process dated 01/01/2000, indicated that the Laundry Department was responsible for the safe and proper collection, cleaning, and distribution of linens within the nursing home. At designated times, laundry workers using a large bin with lid, marked For Soiled Linen Use Only will go to each Soiled Linen Room to pick up the soiled linen. The policy did not indicate for housekeeping to collect soiled gowns from COVID-19 positive resident rooms or other TBP resident rooms. On 02/10/23 at 12:58 PM, the survey team again requested from the LNHA staff education on infection control. The LNHA stated, I thought I told you I gave you all the education I had to give. Surveyor #1 asked if the few in services she provided encompassed the entire facility staff. The LNHA stated she was not sure and, I guess I can have nursing give you the book to see. At 1:23 PM, the ADON IP and RN in training for IP were in the conference room with three surveyors. The ADON IP stated in services and education for staff regarding infection control was on and off and whenever I get a chance. The ADON IP stated there was not always a sign in sheets to identify who received education or what the education was provided. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	At 1:25 PM, Surveyor #3 inquired if a resident tested COVID-19 positive and had a room mate, what would the process be. The ADON IP stated the facility would remove the roommate without COVID-19 and place them into another room. She stated if the roommate was unvaccinated, they would, test them, move them, monitor them, and place them on empiric TBP which means if they become symptomatic, they would be put on isolation until the facility could be sure they were not COVID-19 positive. The ADON IP stated the staff were educated to care for the well resident first unless, something comes up. She stated that trying to have dedicated COVID-19 staff was, challenging, which means very difficult. We (facility) don't have enough staff sometimes. The RN in training for IP stated that as long as the staff followed the TBP, they should be ok. At 1:38 PM, the ADON IP stated the COVID-19 outbreak started the end of October (2022) and, we are not in the big numbers of COVID. When asked what she had implemented since the start of the outbreak, the ADON IP stated, we have a form of auditing. She stated supervisors also do education and, I think there are in services on the nursing units. On 02/10/23 at 2:12 PM in the presence of three surveyors, the DON stated that since the facility outbreak, the facility had tried to have dedicated COVID-19 staff but were unable to. The DON acknowledged that all four wings had both well and ill residents. The LNHA was also present and stated that the facility did not have enough equipment to provide dedicated equipment to residents on TBP. On 02/14/2023 at 11:03 AM during an interview with Surveyor #4, the Director of Housekeeping stated that housekeeping was responsible for picking up soiled gowns from COVID-19 positive resident rooms. He stated the process was to don a PPE gown, gloves, N95 mask, and face shield to enter the room. The resident's bin for disposal of soiled PPE gowns had a plastic bag. The housekeeper would tie the dirty bag and hand the bag to a second person outside the room. The second staff would be holding a clean plastic bag for the housekeeper to drop the tied bag of soiled gowns into so it would be double bagged. The second person standing outside the room would then dispose of the double bagged linen into the linen bin in the hallway. The Director of Housekeeping demonstrated the process and showed the surveyor the different bins in the hallway of Wing 1. One bin for trash, two bins for soiled gowns and/or linen, and a third bin for resident's personal clothes. A review of the facility provided, Outbreak Response Plan, undated, included but was not limited to 1.b. Control Measures .frequent COVID-19 in-services and handwashing as well as PPE education and competencies. A review of the facility provided, Outbreak Investigation/Management policy and procedure revised 02/01/23, included but was not limited to Purpose to manage and contain disease/condition outbreak when identified. Case definitions included MDROs and COVID-19. 7. Implement control measures based on signs, mode of transmission. Measures may include standard and transmission-based precautions. 8. Conduct station education/competencies include hand hygiene, donning and doffing PPE, transmission precautions, MDRO. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility provided, Modified Enhanced Barrier Precautions revised 11/15/21, included but was not limited to Policy: In addition to standard precautions, modified enhanced barrier precautions and contact precautions will be used for MDROs. 5. post the appropriate enhanced barrier precautions or contact precautions sign on the patient's room door. Contact Precautions: required PPE: gloves and gown (don before room entry, doff before room exit; change before caring for another patient) face protection may also be needed if performing activity with risk of splash or spray. 9. Before exiting room, remove and place PPE in trash and perform hand hygiene upon exiting room. 16. Document: type of precautions in care plan. Specific MDRO identification in special instructions section of [redacted] (electronic medical record). Review of the CDS, COVID-19 Patient/Resident Management in Post-acute Care Settings guidance dated 01/23/23, provided to the ADON IP by the LHD, included but was not limited to, When resources permit, facilities should dedicate equipment to individual cohorts. Equipment should not be shared between individuals on TBP and those cared for with standard precautions. If this is not possible, equipment should be used by rounding in a well to ill flow to minimize the risk of cross-contamination. A review of the facility provided, COVID-19 policy and procedure revised 12/07/22, included but was not limited to Policy: in addition to standard precautions, special droplet and contact precautions will be implemented for patients suspected or confirmed with COVID-19. Special droplet and contact precautions requires wearing a N95 respirator upon entry .in addition to the recommended PPE. Definition: all recommended PPE (gown, gloves, eye protection, respirator) while present in the room. Infection Surveillance: 6.2 during an outbreak, the COVID-19 screen will be completed each shift. 31654 27193 Part B The non-compliance remained on 02/27/23 for no actual harm with the potential for more than minimal harm that is not immediate jeopardy. Based on observation, interview, record review and document review it was determined that the facility failed to ensure the faciliy policy for infection surveillance during an outbreak was followed by completing a COVID-19 resident screening each shift (for 4 of 4 Wings), and ensure staff performed hand hygiene as indicated on 1 of 4 Wings. The deficient practice was evidenced by the following: Reference: Centers for Medicare and Medicaid Services Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH DATE: August 26, 2020 REVISED 09/23/2022. Centers for Disease Control and Prevention, COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 02/08/23 at 11:22 AM, during the entrance conference held with the facility Administrator (LNHA) and Director of Nursing (DON), the LNHA informed Surveyor #2 that the facility was currently experiencing an outbreak that began on 10/24/22. The DON informed the surveyor that there were currently twenty-seven COVID positive residents. Surveyor #2 inquired about any COVID-19 testing in progress and the DON stated that per facility policy employees and residents were tested twice per week on Tuesday and Thursday, and only employees would be tested for a COVID-19 exposure. On 02/09/23 at 11:33 AM, the LNHA provided the survey team with a copy of the current Infection Control Policies and Procedures for COVID-19, Effective 03/27/20 and Revised 12/07/22. The Policy revealed: the facility follows the CDC published guidance for patient and/or healthcare personnel (HCP) with suspected COVID-19. Infection Surveillance: 6. Complete the COVID 19 Screen UDA in the electronic medical [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 38079 Based on interview, record review and review of other pertinent documentation, it was determined that the facility failed to follow facility policy and ensure the implementation of a comprehensive antibiotic stewardship program (ASP). This deficient practice was identified during a review for 3 of 3 months of the facility Infection Control Monthly Line Listing tracking forms (December 2022, January 2023, and February 2023). The deficient practice was evidenced by the following: On 02/08/23 at 11:12 AM during entrance conference, the Licensed Nursing Home Administrator (LNHA) stated that the facility was in a current outbreak of COVID-19. A review of the facility provided line list revealed the outbreak began 10/23/22. On 02/10/23 at 2:48 PM, the ADON IP provided Surveyor #1 with Infection Control Monthly Line Listing forms for December 2022, January 2023, and February 2023 up to 02/10/23. A review of the Infection Control Monthly Line Listing form revealed the following information to be documented: Name; Room #; admitted ; Date onset; HAI (healthcare acquired)/C (community acquired); type of symptoms/diagnosis; Culture/Chest x-ray: date taken, site, results; Treatments: abt (antibiotic) type, start date; precaution type; and infection resolved. A review of the December 2022 Line Listing revealed 18 resident entries documented. The facility failed to document the following: Nine of 18 admitted s. Eleven of 18 date onset. Ten of 18 HAI/C. Three of 18 type of symptoms/diagnosis. Seven of 18 abt start date. Eighteen of 18 infection resolve date. A review of the January 2023 Line Listing revealed 20 resident entries documented. The facility failed to document the following: Eighteen of 20 admitted s. Fifteen of 20 date onset. Five of 20 HAI/C. Five of 20 start date. Twenty of 20 infection resolve date. A review of the February 2023 Line Listing revealed four resident entries documented. The facility failed to document the following: Three of 4 admitted s. Two of 4 date onset. Two of 4 HAI/C. One of 4 without the resident's full name. The January 2023 Infection Control Monthly Line List revealed Resident #26 had a date onset of 01/30/23, a diagnosis of pneumonia, no chest x-ray documented, the antibiotic Doxycycline, a start date of 01/30/23, and contact precaution type. The form failed to document if the infection had resolved. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the medical record revealed that Resident #26 had been admitted with diagnoses which included, but were not limited to: sepsis, Congestive Heart Failure, bacteremia, and chronic respiratory failure. A review of the, Order Summary Report dated 02/24/23, failed to list Doxycycline or any antibiotic order. A review of the Medication Administration Record (MAR) dated January 2023, revealed an order for Doxycycline Monohydrate 100 milligram (mg) give 1 capsule by mouth two times a day for pneumonia for 5 days. Start date 01/31/2023. A review of the February 2023 MAR revealed an order for Doxycycline Monohydrate 100 milligram (mg) give 1 capsule by mouth two times a day for pneumonia for 5 days. Start date 01/31/2023 with no end date documented. The medication was signed off as administered until 02/04/23. A review of the Progress Notes (PN) revealed a PN dated 01/31/23, chest x-ray positive for PNA (pneumonia). ABT (antibiotic) started for PNA. A PN dated 02/04/23 revealed ABT doxycycline for pneumonia. A PN dated 02/07/23, ABT Doxycycline for pneumonia. The 02/07/23 PN was documented 3 days post antibiotic and did not address if the pneumonia had been resolved. On 02/24/23 at 9:27 AM, the DON stated to the survey team that the ADON IP was responsible for the ASP. The ADON IP was not available to be interviewed. The DON and the surveyor reviewed the Infection Control Monthly Line Listing forms the ADON IP had provided. The DON stated that the forms were not complete. When asked about specific residents on the Line Listing forms with incomplete information, the DON stated to the surveyors that she was unaware of where the ADON IP kept all the antibiotic stewardship Line Listing forms. The DON further stated she was responsible for the ASP the week of 01/29/23 through 02/08/23, but I did not fill out any forms. Surveyor #1 asked the DON about Resident #26 who was added to the Line Listing on 01/30/23 while the DON was responsible for the ASP. The DON stated that she did not fill out any form to address if the infection was resolved. The DON stated, I don't have anything in the book and that we talk about it as a clinical team. The surveyor asked the DON how an antibiotic would be tracked and monitored if it was not documented. The DON stated to the survey team that the facility would not want to put residents on antibiotics if they were not needed. The surveyor asked the DON about the Line Listing form from February 2023 which failed to document a resident's first name. The DON stated that a resident's complete name should be on the form. The DON stated to the survey team, that the facility would track and document responses to antibiotics such as any side effects, symptoms being resolved, and results from the hospital. The surveyor asked to be provided with the documentation for the resident listed with no first name. The DON stated, I'm looking to see what the nurses documented and I don't see where they (nurses) documented anything. The DON stated that the facility should have observed and assessed how the resident was responding to the antibiotic. The surveyor reviewed the facility ASP with the DON. A review of the facility provided, Antibiotic Stewardship Program revised 11/07/17, included but was not limited to the ASP was based upon the CDC's Core Elements of Antibiotic Stewardship for Nursing Homes. The Core Elements listed were leadership, accountability, drug expertise, action, tracking, reporting, and education. Infection Preventionist monitors and supports through rounds, review of provider orders, documentation and available [redacted] (electronic medical records)/pharmacy/lab reports. Monitors HAI MDROs on Monthly Line Listing. Tracking: monitor both antibiotic use practices and outcomes related to antibiotics in order to guide practice and changes and track the impact of new interventions. Clinical evaluation documentation (i.e., signs/symptoms, vital signs, physical exam findings). Monitoring outcomes of antibiotic use. Education: educational programs will be provided to both nursing staff and clinical providers on the goals of the antibiotic stewardship program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The surveyor asked the DON where the accountability of the ASP would be. The DON stated the accountability would be in the education of the staff and the follow up, but I don't have that. Surveyor #1 asked the DON about the resident clinical response documentation. The DON stated, I don't know if we have that. I have not done it. The DON stated that it was important to perform a time out (stopping an antibiotic) to see if the antibiotic was appropriate. The DON stated that someone could build up a resistance to antibiotics if the antibiotic was not appropriate for the diagnosis. She further stated that she would look for trends like the same bacteria in the same Wing to determine if hand hygiene was a concern. NJAC 8:39-19.4, 27.1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Perform COVID19 testing on residents and staff. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31654 Based on interview and document review, it was determined that the facility, who was experiencing an outbreak of COVID-19 (a potentially deadly virus) failed to take immediate action to prevent the spread of COVID-19 by failing to: a.) follow facility policy and pertinent guidance to conduct immediate COVID-19 testing for residents by either, a broad-based or contact tracing approach when two Certified Nurse Aide's (CNA #1) who was symptomatic with a cough and fatigue worked on Wing 2, tested COVID-19 positive on 02/05/23 and worked on 02/03/23 and 02/04/23, and CNA #2, who was symptomatic with a cough and congestion tested COVID-19 positive on 02/03/23 and worked on Wing 1 on 02/01/23, b.) conduct immediate resident broad-based testing per facility policy on 02/08/23, 02/11/23 and 02/13/23, in response to a COVID-19 positive resident on Wing 2 (Resident #84), who tested positive for COVID-19 on 02/07/23, and conduct resident broad based testing on 02/13/23 in response to Resident #86 who tested positive for COVID-19 on 02/12/23, and c.) ensure a process was followed to ensure all close contacts of a dietary department employee (Employee #3), who was symptomatic and tested positive for COVID-19 on 02/16/23, were identified and tested immediately (a [NAME] worked on 02/16/23) and failed to receive a COVID-19 test on 02/16/23 during routine facility testing and then proceeded to work on 02/17/23, without first being tested for COVID-19). This deficient practice occurred for 3 of 3 employees (CNA #1, CNA #2 and Employee #3) and 2 of 5 residents reviewed for COVID-19 testing (Resident #84 & #86) and was evidence by the following: Reference: Centers for Medicare and Medicaid Services Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements, QSO-20-38-NH DATE: August 26, 2020 REVISED 09/23/2022. Centers for Disease Control and Prevention, COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022. Refer to F880 The failure to conduct immediate resident and staff testing upon utilizing either a broad- based approach or contact tracing approach, upon the identification of a single COVID-19 positive staff or resident result resulted in an Immediate Jeopardy (IJ) situation which began on 02/03/23 when the facility failed to conduct either immediate broad based testing, or contact tracing testing in response to CNA #1, who was symptomatic and also tested COVID-19 positive on 02/03/23 and worked on 02/01/23. The facility was notified of the IJ situation on 02/17/23 at 1:42 PM. The removal plan was received on 02/17/23 at 8:52 PM, and accepted on 02/21/23 at 9:07 AM. The removal plan was verified as implemented by the survey team on 02/21/23 at 1:08 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/08/23 at 11:22 AM, during the entrance conference held with the facility Administrator (LNHA) and Director of Nursing (DON), the LNHA informed the surveyor that the facility was currently experiencing an outbreak that began on 10/24/22. The DON informed the surveyor that there were currently twenty-seven COVID-19 positive residents. The surveyor inquired about any COVID-19 testing in progress and the DON stated that employees and residents were tested twice per week on Tuesday and Thursday, and only employees would be tested for a COVID-19 exposure. On 02/09/23 at 11:43 AM, the Assistant Director of Nursing, Infection Preventionist (ADON IP) stated she had been in contact with the Local Health Department (LHD) either, today, yesterday, or the other day. She stated that the LHD had provided her with the Communicable Disease Services (CDS), COVID-19 Patient/Resident Management in Post-acute Care Settings guidance dated 01/23/23. On 02/13/23 at 1:15 PM, the LNHA provided the survey team with a copy of the Centers for Disease Control and Prevention, COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Updated Sept. 23, 2022, which she stated was their reference for COVID-19 policies. The document revealed Perform SARS-CoV-2 Viral Testing; Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test for SARS-CoV-2 as soon as possible.; Asymptomatic patients with close contact with someone with SARS-CoV-2 should have a series of three viral tests for SARS-CoV-2 infection. Testing recommended immediately (but not earlier than 24 hours after the exposure), and if negative, again 48 hours after the first negative test and, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0, day 3, and day 5. Create a Process to Respond to SARS-CoV-2 Exposures Among HCP (Health Care Personnel) and Others; Healthcare Facilities should have a plan for how SARS-CoV-2 exposures in a healthcare facility will be investigated and managed and how contact tracing will be performed. On 02/14/23 at 12:56 PM, the surveyor asked the facility Assistant Director of Nursing Infection Preventionist (ADON IP) what the purpose was for identifying a close contact. The ADON IP stated, to make sure the close contact will be aware and make sure they do not get sick and we test the close contacts for COVID-19. On 02/14/23 at 1:56 PM, a surveyor conducted a telephone interview with the Registered Nurse from the Local Health Department (LHDRN). The LHDRN stated that she informed the facility to follow all Communicable Disease Services of the Department of Health guidance regarding the outbreak. The LHDRN stated she informed the facility ADON IP to follow contact tracing guidance and recommended if the facility was unable to perform contact tracing, they should have tested the whole floor or unit and/or the whole facility. She stated she informed the facility that COVID-19 testing should be completed on day 1, 5, and day 7. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/14/23 at 2:06 PM, the DON provided the surveyor with the facility undated Performing Contact Tracing document. The document revealed contact tracing slows the spread of COVID-19 by: Letting people know they may have been exposed to COVID-19 and should monitor their health for signs and symptoms of COVID-19, Helping people who may have been exposed to COVID-19 get tested .A close contact is defined as. 1) someone who was within 6 feet of an infected person for a total of 15 minutes or more, and 2) laboratory confirmed or probable COVID-19 patients. This is regardless of wearing cloth face coverings and PPE. Testing is recommended for all close contacts of confirmed or probable COVID-19 patients .Contact Tracing Workflow for COVID-19, 1. Infected/suspected person interviewed; a. Include status 48 hours prior to exposure; b. Questions to ask regarding exposure: 1. Was the individual tested , 4. When eating (on breaks, etc.) were employees socially distanced, on per table (if appropriate) and facing the same direction .For more detailed information, see Key Information to Collect During a Case Interview from the CDC; 4. Fill out contact tracing log; a. Update information as soon as possible,; b. Infection Preventionist/Center leadership to maintain on Center Share Drive. On 02/15/23 at 9:54 AM, a surveyor interviewed the DON and ADON IP in the presence of the survey team. The surveyor inquired what the contact tracing process entailed. The ADON IP stated if a resident tested positive for COVID-19 that they would find out who the contacts were, who took care of the resident, and if there had been visitors. The ADON IP stated that they would go back and look for a forty-eight-hour period to determine the contacts. The ADON IP stated that when they determined the contacts, they would be tested for COVID-19 the day after the exposure, and then the third and fifth day after exposure. On 02/17/23 at 8:56 AM, the DON provided the facility line listing (LL) to the survey team. The surveyor reviewed the LL which revealed that the initial Onset Date for the first listed Resident on the LL was 10/23/2022, not 10/24/2022 as indicated by the LNHA during the entrance conference, and listed four additional COVID positive staff which included a dietary staff (Employee #3) who was symptomatic with myalgia (muscle pain) and a headache, and tested COVID-19 positive on 02/16/23. The surveyor asked who was completing the contact tracing (a process to determine who came into contact with someone who had an infectious illness) and the DON stated the ADON IP was responsible for all the contact tracing. On 02/17/23 at 9:18 AM, the surveyor interviewed the Food Service Director (FSD), regarding when he had been tested for COVID-19. The FSD stated yesterday (02/16/23) he was tested since it was Tuesday and was the routine testing day. The surveyor asked if he had been aware that Employee #3 was symptomatic, and stated he was not aware. The surveyor asked the FSD if the DON or ADON IP had asked any questions regarding Employee #3 which may have included who Employee #3 had come into contact with, and what her job functions consisted of. The FSD stated no, that he had been informed that the Employee #3 tested positive for COVID-19, and that she needed to go home to quarantine. The surveyor asked what jobs Employee #3 was responsible for, in addition to the observations made by the surveyor on 02/15/23 from 11:37 AM to 12:08 PM when the surveyor observed Employee #3 who had been preparing resident meal trays on the tray-line and was also observed positioned opposite of the cook. The FSD stated that Employee #3 had also been responsible for serving meals to residents in the dining room and when asked what type of mask Employee #3 had worn, he stated a surgical mask. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/17/23 at 9:23 AM, in the kitchen, the surveyor observed the cook, prepping food and was wearing a surgical mask that was not fully covering his nose. The surveyor asked the cook if he had been tested on [DATE] for COVID-19. The cook confirmed he had worked on 02/16/23 and stated, no, not yesterday. The cook stated then he was supposed to come in today to get tested , and he went to the testing area and there was no one there to do his test and he started working. On 02/17/23 at 9:25 AM, the surveyor, again, interviewed the FSD. The surveyor asked the FSD if he had been aware that the [NAME] was not tested for COVID-19 on 02/16/23. The FSD stated, no, I was not aware and I was not told. The FSD stated that no one had told him that the [NAME] was not tested for COVID-19 during the routine testing conducted on 02/16/23. On 02/17/23 at 9:35 AM, the surveyor, in the presence of the survey team, interviewed the IP and DON. The surveyor asked the DON if the facility was still in an outbreak, and she stated yes. The surveyor asked what the process was for staff to be tested routinely. The ADON IP stated routine testing doesn't have to be done prior to the employees shift, only if the staff is symptomatic, they will be tested first. If a staff member was exposed, they should be tested the next day. The DON stated if staff were here on the routine testing days, they must be tested . The ADON IP then stated before the employee starts their shift, they must be tested , which was confirmed by the DON. The surveyor asked how they know everyone is tested ; the DON stated they use a staffing sheet. The surveyor asked what the testing policy was for an outbreak. The ADON IP stated, I don't know if there is a policy, there is no specific guidance other than if the person was exposed. The surveyor asked if the cook should have been tested on [DATE]. The ADON IP stated that she didn't have the cook on the schedule and was unaware that he had worked with the DS forty-eight hours back from when she had tested positive for COVID-19 on 02/16/23. The ADON IP stated the cook should have been tested yesterday and today (02/17/23) and stated, I didn't know he wasn't tested . On 02/17/23 at 9:50 AM, the surveyor asked the ADON IP, in the presence of the DON, what was process used to gather information regarding the contact tracing for the close contacts of Employee #3. The ADON IP stated she went to Employee #3 to ask who Employee #3 worked with and stated, I don't really ask many questions to the supervisor, only to the person. The surveyor then asked the ADON IP if Employee #3 had direct contact with any residents, and the ADON IP stated she was unaware and that she had not asked the FSD that question. The surveyor asked if the supervisors should be questioned regarding staff responsibilities during contact tracing. The DON stated yes, absolutely and supervisors should be included in the contact tracing process, and at that time the DON confirmed there was no documented process for completing contact tracing. On 02/17/23 at 10:04 AM, the surveyor interviewed the FSD regarding what time Employee #3 was tested on [DATE]. The FSD stated around 2:30 PM, and then Employee #3 left at 3:00 PM after working her full shift. The FSD stated he tried to get the staff to test earlier and sometimes there would be an overhead intercom announcement. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/17/23 at 10:29 AM, the surveyor reviewed the LL which revealed Resident #84, who resided on Wing #2, was symptomatic with congestion and fatigue, tested positive for COVID-19 on 02/02/23. The surveyor asked the DON what testing was completed in response to Resident #84 testing positive for COVID-19. The DON stated all residents were tested , and stated 02/07/23 was day zero, then day one was the next day. The surveyor asked the DON if a contact tracing or broad-based (testing individuals within a particular location, including facility wide, when all contacts who may have been exposed cannot be identified), and all the staff and residents were included. The surveyor asked the DON to confirm the date of testing completed for Resident #84. The DON stated 02/08/23 was the date that all of the COVID-19 testing was completed for Resident #84, and the surveyor asked to see all of the testing information. The DON looked on her computer, and stated, I don't have anything for that date for that unit [Wing 2], I don't see it there, no it was not done. The DON stated she had COVID-19 testing for 02/09/23 (Thursday, a routine testing date), and stated 02/11/23 (Saturday) would be day three of the required outbreak testing for Resident #84. The DON stated, I don't have anything (COVID-19 testing) listed there. The DON confirmed that the next broad-based COVID-19 testing day in response to Resident #84 would be for day five and that would be on 02/13/23 (Monday). The DON stated, I don't have anything listed for the 13th, no, I don't have it, if it was done it should be there, and everything should be entered in here (computer). The surveyor continued to review the LL which revealed, Resident #86, who resided on Wing 3, was asymptomatic and tested positive for COVID-19 on 02/12/23. On 02/17/23 at 10:47 AM, the surveyor requested all testing that was completed regarding Resident #86 testing positive for COVID-19 on 02/12/23. The DON stated that the broad-based testing should have been completed on 02/13/23, which would have been the required day 1 testing. The DON stated, it should have been done, and confirmed it was not completed and the DON stated she does not know why it was not completed, and she will look for it. On 02/17/23 at 10:41 AM, a further review of the LL by the surveyor revealed two Certified Nurse Aide's, (CNA #1) who was symptomatic with cough and fatigue, and who worked on Wing 2, tested COVID-19 positive on 02/05/23 and worked on 02/03/23 & 02/04/23, and CNA #2, who was symptomatic with cough and congestion, tested COVID-19 positive on 02/03/23 and worked on Wing 1 on 02/01/23. The surveyor requested any contact tracing and any COVID-19 testing related to either CNA. The DON stated that there was no contact tracing completed for either CNA. The surveyor asked if there was a file, or anything in writing regarding the contact tracing. The DON stated nothing was written down, there was no file and confirmed that CNA #2 worked on 02/01/23, caring for residents, and on 02/03/23 tested COVID-19 positive. The DON confirmed that contact tracing should have been completed and that there was no contact tracing completed on or testing completed, on 02/04/23. She stated there was nothing, and unfortunately no one was doing it when she (IP) was out. The DON provided CNA #1's time punch logs which confirmed CNA #1 worked on 02/03/23, on 02/02/23; and CNA #2 worked on 02/01/23. On 02/17/23 at 11:31 AM, the DON confirmed the day 1, 3, 5 broad- based testing was not completed in response to Resident #84 who tested COVID-19 positive on 02/07/23 and she did not have documented evidence to support that it was completed. In addition, the DON confirmed that the day 1 testing that should have been completed in response to the 02/12/23 COVID-19 positive test result for Resident #86 had also not been completed, and she was unable to provide documented evidence for completion. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0886 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 02/17/23 at 11:43 AM, the DON provided testing documentation to the surveyor for: 02/10/23, Wing 3, and 02/12/23, Unit 3 [Wing 3] Residents and staff secondary to exposure. The DON again, confirmed there was no testing that had been completed on 02/13/23, in response to Resident #86, who resided on Wing 3. At that time, the DON again stated there had been no testing completed on Wing 2, in response to Resident #84's COVID-19 positive test result on 02/07/23. On 02/17/23 at 11:46 AM, LNHA provided time stamp log for the [NAME] which revealed the [NAME] worked on 02/15/23 from 6:07 AM to 6:51 PM; 02/16/23 from 11:11 AM to 7:15 PM; 02/17/23 he punched in at 8:56 AM. The Employee #3 time stamp log revealed that Employee #3 worked on 02/14/23 from 7:03 AM to 1:30 PM; 02/15/23 (three separate time punches) from 6:51 AM to 1:00 PM, from 1:30 PM to 3:04 PM, and from 4:00 PM to 7:30 PM; 02/16/23, 7:02 AM to 12:57 PM, and a second punch log from 1:30 PM to 3:17 PM. Review of the facility COVID-19 Policy, Effective 03/27/20, Revision Date 02/14/23, revealed Definitions: Broad Based Testing requires testing of all individuals within a particular location (unit, wing, floor, facility-wide). Used most often due to the difficulty of ascertaining ALL contacts who may have been exposed to a COVID positive person.; Contact tracing is testing process that requires identifying all of the potential contacts within a patient/person who tests positive for COVID-19 testing.; Contact Tracing is a testing process that requires identifying all of the potential contacts with a patient/person who tests positive for COVID-19 for testing.; Purpose: To prevent the development and transmission of COVID-19.; Practice Standards: 4. Outbreak testing is completed utilizing broad based or contact tracing approach.; 5. Centers will conduct testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests .; 5.2. Completed tests and results will be properly documented and reported as required.; 18. Follow CDC published guidance for patient or HCP with suspected COVID-19.; 20. Perform contact tracing for both suspected and confirmed cases and document on Contact Tracing Log.; 10.1 A broad based approach is utilized to investigate a possible COVID-19 outbreak.: 21. Centers will have a plan based on CDC/CMS/state/local recommendations to prevent transmission, such as having a dedicated space in the facility for cohorting and managing care for patients with COVID-19. Testing for COVID-19: 35. Patients, facility staff, and visitors will be tested according to CMS and state Department of Health requirements and [corporate] guidance.; 35.1 COVID-19 testing results will be documented. NJAC 8:39-5.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 31654 Based on observation, interview and document review, it was determined that that facility failed to ensure that contracted facility departments received training and competencies in accordance with the Facility Assessment, and to ensure facility policies and procedures for infection control standards were met. This deficient practice affected 4 of 4 Resident Wings and was evidenced by the following: On 02/08/23 at 11:12 AM, during the facility entrance conference the Licensed Nursing Home Administrator (LNHA) provided a copy of the Facility Assessment Tool (Tool), dated 03/22/22. The Tool revealed staff training/education and competencies, 3.4. Describe the staff training/education and the competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies. At facility staff members are provided with training and education beginning with the new hire orientation and regular on-going training. All staff members are provided with annual education and competencies that are necessary to their job responsibilities. On 02/08/23 at 10:58 AM, on the 1st Wing, Surveyor #1 and #2 observed a laundry aide walking down the hallway and was wearing a Personal Protective Equipment (PPE) gown which was not secured in the back, an N95 mask and eye protection. The laundry aide then entered a COVID-19 positive resident room, and through an open door, the surveyors observed her touch multiple environmental surfaces including a dresser, and folded clothes, and proceeded to go to the other side of the room and touch other surfaces, including the furniture. She exited the room without first removing gloves and performing hand hygiene. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The laundry aide did not perform hand hygiene upon exiting the room and proceeded to continue to wear the same gloves. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/10/2023 at 10:49 AM on Wing 4 of the facility, Surveyor #4 observed a housekeeper wearing an N95 mask and a face shield. The housekeeper was observed to don (put on) a PPE gown and gloves, enter a resident room, picking up soiled gowns and collecting soiled gowns in a see-through plastic bag. The housekeeper doffed (removed) his PPE gown and gloves inside the resident room, brought the bag with soiled PPE out into a cart in the hall and next sanitized his hands. The housekeeper was next observed in the doorway of a COVID-19 positive resident room wearing an N95 mask and face shield. The COVID-19 positive room had signage on the door to indicate what the TBP was and what PPE was to be worn. The signage indicated Special Contact and Droplet Precautions for special respiratory circumstances and included but was not limited to performing hand hygiene before and after patient contact, contact with environment and after removal of PPE; and wear an N95 respirator, gown, face shield and gloves upon entering this room. The housekeeper had not donned a PPE gown or gloves. The housekeeper was using his bare hands to tie a plastic bag that contained used, soiled PPE gowns. The housekeeper then brought the plastic bag filled with soiled PPE gowns out into the hallway and placed the bag on top of the housekeeping cart. Surveyor #4 asked the housekeeper what the process was for collecting soiled gowns in resident rooms for residents were on droplet precautions or any transmission-based precautions (TBP). The housekeeper stated that he followed directions from his administrator. The housekeeper was unwilling to answer any additional questions from the surveyor and stated, please let me get back to work and do my job. On 02/10/23 at 12:58 PM, a surveyor asked the LNHA again for a staff education book, or documented education. The LNHA stated I thought I told you I gave you all the education I had to give, and the surveyor asked if the in services shehad provided encompassed the entire staff. The LNHA stated she was not sure and I guess I can have nursing give you the book to see. On 02/10/23 at 2:02 PM, the facility Assistant Director of Nursing Infection Preventionist (ADON/IP) stated to the survey team that she and the Director of Nursing (DON) were responsible for the staff education. On 02/10/23 at 2:38 PM, the surveyor interviewed the DON and LNHA in the presence of the survey team. The LNHA stated the nurse managers and department heads complete infection control rounds. The DON stated that when rounds were completed, there was no sign in sheet to show who had been provided with the education or the topic of the education. On 02/14/23 at 11:03 AM, the surveyor interviewed the Director of Housekeeping (DOH) who stated that housekeeping was responsible for picking up soiled gown from Covid-19 positive resident rooms. The process was to don PPE including a gown, gloves, N95 mask, and face shield prior to entering. The DOH stated the bin for gowns had a plastic bag inside and the housekeeper would pick up soiled gowns in the bag then tie the bag, then a second person would be outside of the room and holding a plastic bag. The housekeeper would then drop the tied bag of soiled gowns into the second plastic bag outside the room. The DOH stated it was double bagged and then the person standing outside the room would then tie the bag and place inside the linen bin in the hallway. The DOH demonstrated the process and showed the surveyor the different bins in the hallway of Unit 1. One bin for trash and two bins for soiled gowns/linens and a third bin for personal clothes. On 02/13/23 at 12:22 PM, the surveyor interviewed the LNHA who stated that she had been at the facility since November 2021. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/13/23 at 12:24 PM, the surveyor requested all education and staff competencies regarding hand washing, putting on and removing personal protective equipment (donning and doffing PPE and infection control education and competencies for all staff). The LNHA stated she had been responsible for overseeing the staff education process and auditing the inservice education and competencies. The LNHA stated the Infection Preventionist and department heads received infection control training and have been doing infection control rounds with on-the-spot training. The surveyor asked the LNHA if the education was documented, and the LNHA stated, we didn't have the documentation. On 02/13/23 at 1:03 PM, the LNHA confirmed to the survey team that all the education that had been provided to the surveyors was what the facility had. The LNHA stated the facility utilizes an online education system, and there is not necessarily competencies. The LNHA stated there has been anyone fulfilling a staff educator role at the facility for a few months. The LNHA stated that if there was a need for specific education for a new procedure, and the LNHA used the example of providing intravenous nutrition, the facility would do a refresher education as needed. however, nothing formally documented. The surveyor inquired as to who would be providing any specialized education, including education on infection control, and the LNHA it would be a combination of different managers. The surveyor asked if there was any documented evidence of the education, and the LNHA stated, no. On 02/13/23 at 1:12 PM, the surveyor inquired regarding what the policy was for removing COVID-19 positive resident meal trays. The LNHA stated we don't have a policy, we have a process and we do well to ill and we would collect all the non-precaution trays and take care of those residents first, then we take care of the isolation trays, and we bag them. The LNHA stated we were supposed to have the process in place. The LNHA stated we don't have anything documented regarding training the staff on picking up the covid positive resident trays. On 02/22/23 at 10:08 AM, the surveyor asked to LNHA to review facility assessment regarding infection control. The surveyor asked the LNHA what the purpose of the facility assessment was. The LNHA stated to look and see that we can meet the resident's needs, and if we had a certain type of population, we would make sure the staff had the resources and training, including regarding any religions. The surveyor asked if any resources were identified for infection control, the LNHA stated it doesn't specifically lay it out, and the surveyor asked were there any trainings, or competencies identified in the facility assessment. The LNHA stated there was nothing specific to infection control in the facility assessment, it should be more specific. On 02/24/23 at 11:39 AM, the surveyor interviewed the LNHA regarding any education and competencies that had been provided by the contracted departments which included housekeeping and dietary. The LNHA stated she spoke to housekeeping, and they informed her that they did not complete educational competencies with their staff. The LNHA stated there was specific education related to each department and then the departments all participated in the facility education. The surveyor asked the LNHA to review the facility education book to locate any educational competencies for housekeeping since the housekeeping director confirmed that he did not complete them. The LNHA stated she was not aware that housekeeping director did not do competencies. The surveyor specifically asked about donning and doffing related to the observations made during the survey. The LNHA stated the donning and doffing competencies should have been completed by the facility and stated, I am not finding the housekeeping department in the competency book, clearly there is no process. The LNHA stated she looked through the education book and stated that there is no list for what educational competencies should have been provided by each department. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315138	A. Building B. Wing	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Troy Hills Center	200 Reynolds Ave Parsippany, 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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NJAC 8:39-13.4 (b)