STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING _____ B. WING _____	08/24/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** C#: NJ: 8, 5, 3 Based on interviews, and record review, as well as review of pertinent facility documents on [DATE] it was determined that the facility failed to document upon discharge the Resident's personal belongings on the Inventory form for 2 of 6 Residents (Resident #2 and Resident #5) reviewed for inventory of belongings and failed to notify and document that the Primary Physician (PP) of Resident's refusal of medication for 1 of 6 Residents (Resident #4) reviewed for medication administration. These deficient practices are evidenced by the following: 1. According to the Admission Record (AR) form, Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated [DATE], Resident #2 had severe cognitive impairment and required extensive assistance from staff with Activities of Daily Living (ADL). The Progress Notes (PN) for Resident #2 dated [DATE] at 1:43 am, showed that the Resident expired. The INVENTORY OF PERSONAL EFFECTS (IPE) form for Resident #2 showed list of items such as but not limited to: blouses, socks and shoes that the Resident or Resident Representative (RR) had brought for personal use of the Resident on admission. However, upon discharge on or after [DATE], there was no documentation to indicate on the IPE form that the Resident's personal items were sent or picked up by the RR. In addition, there was no documentation on the Resident's medical record that the RR had refused to pick up the Resident's personal items. 2. According to the AR form, Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The MDS dated [DATE], showed that Resident #5 had no cognitive impairment and required extensive assistance from staff with ADL. The Care Plan (CP) initiated on [DATE], showed that the Resident showed potential for discharge. The undated IPE form for Resident #5 showed no documentation to indicate that Resident's personal items were sent or picked up by the RR. In addition, there was no documentation on the Resident's medical record that the RR had refused to pick up the Resident's personal items. The surveyor conducted an interview with the Director of Nursing (DON) on [DATE] at 3:00 pm. The DON explained that IPE form had to be signed upon discharge by the Resident or Resident Representative. Discharges includes but not limited to: death or hospitalization . The DON stated that nurses were responsible to ensure that the Resident/RR signed the IPE form. The facility's Job Description titled Staff Nurse was created on ,[DATE] showed .Staff Nurse Essential Duties and Responsibilities: 3. Directs day to day functions of other nurses and Certified Nursing Assistants, as assigned to assure compliance with the state and federal regulations and facility .processes . The undated form titled INVENTORY OF PERSONAL EFFECTS under Discharge/Move out section showed Upon discharge/move out, personal items are sent with resident/patient or picked up by the responsible party . 3. According to the AR form, Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS, dated [DATE], Resident #4 had moderate cognitive impairment and required extensive assistance from staff with ADL. The CP initiated on [DATE] and revised on [DATE] showed that the Resident had a Hepatic condition. The intervention included but was not limited to: administer medications per physician order. The Order Summary Report (OSR) ranged from [DATE] to [DATE], showed an order for [REDACTED]. The MAR for ,[DATE] showed that Resident #4 refused [MEDICATION NAME] on [DATE] at 9:00 am and on [DATE], [DATE] and [DATE] at 1:00 pm. The MAR for ,[DATE] showed that Resident #4 refused [MEDICATION NAME] on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] to [DATE] at 9:00 am, on [DATE], [DATE], [DATE] to [DATE], [DATE] to [DATE] and [DATE] at 1:00 pm, and on [DATE] at 5:00 pm. The MAR for ,[DATE] showed that Resident #4 refused [MEDICATION NAME] on [DATE] at 9:00 am, on [DATE] at 1:00 pm and at 5:00 pm. Resident #4's Progress Notes (PN) for ,[DATE], ,[DATE] and ,[DATE] showed that there was no documentation to indicate that the Resident's Primary Physician (PP) was notified that Resident refused [MEDICATION NAME] on the aforementioned dates and times. Furthermore, there was no documentation from the PP that he was aware of the Resident's consistent refusal of the [MEDICATION NAME] medication. The facility's Job Description-Staff Nurse created on ,[DATE] showed that: .Staff Nurse Essential Duties and Responsibilities .11. Communicates to physician and documents changes in resident condition . The facility's policy titled Requesting, Refusing and/or Discontinuing Care or Treatment revised ,[DATE] showed that: .#6. If a resident requests, discontinues or refuses care or treatment, the Unit Manager, Charge Nurse or Director of Nursing Services will meet the resident to: a. determine why the resident is .refusing care or treatment .11. Detailed information relating to the request, refusal or discontinuation of care or treatment will be documented in the resident's medical record. 12. Documentation pertaining to a resident's .refusal .shall include at least the following: .e. That the resident was informed .of the purpose of the treatment and the potential outcome of not receiving the medication/or treatment .g. The date and the time the practitioner was notified as well as the practitioner's response; .13. The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request . NJAC 8:,[DATE].1 (a)

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

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