STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 009 SS=D	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.	E 009		7/29/24

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

Electronically Signed | 08/16/2024

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E 009	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan and Program (EPP), it was determined that the facility failed to ensure that a copy of the EPP was sent to the local and county office of emergency management (OEM) for annual review. This deficient practice was evidenced by the following: On 7/15/24 the surveyor reviewed the facility provided Emergency Preparedness (EP) binder. The EPP had an annual reviewed date of 02/29/24. The surveyor did not observe documented evidence a copy of the EPP was sent to the OEM. The surveyor requested from the US FOIA (B) (6) the documented evidence. On 7/16/24 at 9:48 AM, the US FOIA (B)(6) provided the surveyor an email dated 7/15/24 5:57 PM which included the following: Attached is the ...EPP for building located at US FOIA (B) (6) sent over to you on 3/21/24. Please verify you received and approved our plan .... The surveyor then requested from the US FOIA (B) a copy of the 3/21/24 email that was referenced. On 7/16/24 at 01:37 PM, in the presence of the survey team, the US FOIA (B) (6) stated that he could not find the email that was sent to the US FOIA (B). He stated that he only had an email that was from the US FOIA (B) to him that verified the US FOIA (B) sent it. The US FOIA (B) confirmed that he did not have any documented evidence that the EPP was sent to the US FOIA (B).	E 009	1. The facility sent a copy of the Emergency Preparedness Plan to the local and county office of emergency management for annual review. 2. No residents were affected were affected by this practice. The Administrator/designee conducted an audit of the Emergency Preparedness Plan to ensure it was in compliance. 3. (7/16/24) Education provided by the regional administer to the US FOIA (B) (6) and US FOIA (B) (6) regarding the requirement to ensure annual review of the EPP by local and county OEM. 4. Audits of Emergency Preparedness Plan will be conducted by Administrator/ designee weekly for 4 weeks, then monthly for three months, to ensure that the Emergency Preparedness Plan is communicated to the local and county office of emergency management for annual review. Results of the audit will be reviewed by the administrator monthly at the QAPI meeting for 3 months.	

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E 009	Continued From page 2 The facility did not provide any additional information. N.J.A.C. 8:39-31.6(f),(h).	E 009		
F 000	INITIAL COMMENTS Complaint and FRE #s: NJ#163775, #168260, #169038, #169874, #170354, #171576, #172084, #172836, #174154, and #174161 Survey Date: 7/24/24 Census: 260 Sample: 35 sample + 3 closed records = 38 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		7/29/24

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F 550	Continued From page 3 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that residents were served their meals in a dignified manner during meal service. This deficient practice was observed for one (1) of five (5) residents (Resident #105), in one (1) of three (3) dining rooms. The deficient practice was evidenced by the following: On 7/08/24 at 11:40 AM, the surveyor observed	F 550	1. NJ ex order 26.4 Resident (#105) the US FOIA (b received and set up the lunch tray in the NJ Ex dining room. US FOIA (b)(6) was verbally educated by Director of Nursing on facility's Dining Environment Policy: All residents seated at a table will be served together, when feasible. 2. All residents receiving meals in the dining room have the potential to be affected.	

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F 550	Continued From page 4 the lunch food truck parked in front of the nursing station of [NJ Ex] unit. The Concierge staff took the lunch truck into the Dining room wherein there were five residents inside the room. At that time, the surveyor observed the [US FOIA (B) (6)] enter the [NJ Ex] dining room and five residents were served lunch trays except for Resident #105. Resident #105 was seated at one table where there were two other residents. On 7/08/24 at 11:45 AM, the surveyor observed in the [NJ Ex] unit dining area during mealtime the US FOIA (B) (6) came to the dining room. The surveyor asked the [US FOIA] why Resident #105 NJ ex order 26.4b1 and NJ ex order 26.4b1 on the same table. The [US FOIA] stated that the [US FOIA (B)] had requested the tray already and was aware that there was no tray in the lunch food truck that was delivered earlier for Resident #105. The [US FOIA] further stated that she did not know why there was no tray for Resident #105 when the food truck was delivered. On 7/08/24 at 11:54 AM, the surveyor observed the [US FOIA (B)] received and set up the lunch tray of Resident #105 in the [NJ Ex] dining room. On 7/12/24 at 10:27 AM, the survey team met with the US FOIA (B) (6) and US FOIA (B) (6) The surveyor notified the facility management of the above concerns. On 7/12/24 at 12:41 PM, the surveyor interviewed the Infection US FOIA (B) (6) The surveyor notified the [US FOIA (b)(6)] of the above concerns. The [US FOIA (b)(6)] stated that the	F 550	3. The DON/ designee re- educated nursing staff on the facility's Dining Environment Policy: All residents seated at a table will be served together. Dayroom seating chart implemented. 4. The administrator /designee will observe one meal per week in the dining room x 4 weeks and then every 4 weeks x 2 months to ensure all residents seated at a table will be served together. The findings of these audits will be reported to the monthly QAPI meeting	

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F 550	Continued From page 5 resident at the same table should have served at the same time. A review of the facility's Dining Environment Policy with a reviewed/revised date of February 2024 that was provided by the [US FOIA (B)], revealed in the Policy Interpretation and Implementation: #6. All residents seated at a table will be served together, when feasible... On 7/16/24 at 02:11 PM, the survey team met the [US FOIA (B) (6)] and [US FOIA (B) (6)] for an Exit Conference. The facility did not provide additional information and did not refute the findings.	F 550		
F 607 SS=E	N.J.A.C. 8:39-4.1(a)12 Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes	F 607		7/29/24

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F 607	Continued From page 6 occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure a.) license verification was checked for three (3) out of seven (7) licensed staff (Staff #1, #3, and #6) b.) criminal background check done for one (1) out of 10 staff (Staff #10) and c.) obtain current and past-employer reference checks for six (6) out of 10 staff (Staff #1, #3, #7, #8, #9, #10). This deficient practice was evidenced by the following: 1. On 7/17/24 at 9:00 AM, two surveyors reviewed ten randomly selected facility employee files and revealed the following: A review of Staff #1 (S#1), the US FOIA (B) (6) [redacted], hired NJ ex order 26.4b1. S#1 file did not have a New Jersey Division Consumer Affairs (NJDCA) license verification printout or the copy of the license. There was no evidence of reference checks from past employers in the file. Review of S#3, the Licensed Practical Nurse	F 607	1. No residents were affected by the deficient practice. References were obtained for Staff #1, #3, #7, #8, #9, #10. License verification was completed for Staff #1, #3, and #6; the facility could not retroactively correct the fact that license verification had occurred post-hire. The facility could not retroactively correct the fact that criminal background check for Staff #10 occurred post-hire. 2. All residents have the potential to be affected. 3. The US FOIA (B) (6) [redacted] was reeducated on the facilities abuse prevention program policy. 4. The Director of Human Resources/designee will audit 3 employee files per week x4 weeks and then every 4 weeks x2 months to ensure license verification, references, and criminal background checks are conducted prior to	

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F 607	Continued From page 7 (LPN), hired NJ ex order 26.4b1. There was no evidence of the reference checks from past employers in the file. Review of S#5, the US FOIA (b)(6)), hired on NJ ex order 26.4b. The NJDCA license printout was dated NJ ex order 26.4b. The verification was completed after the staff member was hired. There was no documented evidence that S#5's license was verified prior to the date of hire (doh). 2. On 7/16/24 at 10:28 AM, the surveyor reviewed five of ten randomly selected new employee files. The review for license verification for one of the new licensed employees revealed the following: Review of S#6, a US FOIA (b)(6), hired on NJ ex order 26.4b1, had a NJDCA license verification printout (used to verify the status of a license for license verification) dated NJ ex order 26.4b1. The verification was completed after the staff member was hired. There was no documented evidence that S#6's license was verified prior to the doh. The review for reference check for four of the five new employees revealed the following: Review of S#7, a US FOIA (b)(6), hired on NJ ex order 26.4b did not have documented evidence in their employee that a reference was obtained. Review of S#8, an US FOIA (b)(6), hired on NJ ex order 26.4b1, did not have documented evidence in their employee that a reference was obtained. Review of S#9, a US FOIA (b)(6), hired on NJ ex order 26.4b did not have documented evidence in their employee that a reference was obtained. Review of S#10, a US FOIA (b)(6), hired on NJ ex order 26.4b1,	F 607	date of hire. -The findings of these audits will be reported to the monthly QAPI meeting	

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F 607	Continued From page 8	F 607		

did not have documented evidence in their employee that a reference was obtained.

The review for NJ ex order 26.4b1 for one of the five new employees revealed the following: Review of S#10, hired on NJ ex order 26.4b1, had a NJ ex order 26.4b1 The NJ ex orde was ordered and reported NJ ex order 26.4b1. A review of a Time & Attendance-Employee Punch History form in the file indicated S#10 punched in and out on NJ ex order 26.4b1 and NJ ex order 26.4b1

On 7/16/24 at 10:53 AM, in the presence of the survey team, the surveyor interviewed the US FOIA (B) (6) via telephone on speaker regarding the process for new employee hire. The US FOIA (B) (6) stated that upon hire for nursing and rehab the license was run through a website to verify or if the employee provided a current license she would take a copy of the license. The surveyor asked the US FOIA (B) (6) when the license was verified. The US FOIA (B) (stated that the doh was when she verified the license. She added that the doh was when the employee was entered into the system and that sometimes the employee did not start work for a week or 2 after that.

On that same date and time, the surveyor notified the US FOIA (B) (6) that S#6's license verification was done after the doh. The US FOIA (B) (confirmed that the license verification should have been done on NJ ex order 26.4b1 and that she was not the person that did the file. The surveyor also notified the US FOIA (B) (that S#1's did not have a license verification. The US FOIA (B) (6) stated that she had done an audit of the files and that there was a copy of S#1's physical license in the file. The surveyor then notified the

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US FOIA (B) (6) that S#5's license verification was done months after their doh. The US FOIA (B) (6) stated that S#5 was a transfer from the agency and that the agency would verify the license and provide it to the facility. The US FOIA (B) (6) did not have the verification.

At that same time, the surveyor asked the US FOIA (B) (6) the process for reference checks. The US FOIA (B) (6) stated that she would get two references and that they would be in the file. She added that in some cases if the employee was NJ ex order 26.4b1 they could only provide one. The surveyor asked the US FOIA (B) (6) the process for criminal background check. The US FOIA (B) (6) stated that it should be done upon hire. The surveyor notified the US FOIA (B) (6) that S#10's BSR was dated NJ ex order 26.4b1, two days after the doh. The US FOIA (B) (6) stated that S#10 started in NJ Exec O The surveyor then notified the US FOIA (B) (6) that documentation in the file had S#10 punched in on NJ ex order 26.4b1. The US FOIA (B) (6) stated that it should have been done prior to the start date.

On 7/16/24 at 11:49 AM, in the presence of the survey team, the surveyor notified the US FOIA (B) (6) the concerns that S#1, S#5 and S#6 did not have a license verification prior to their doh, S#10 did not have a BSR done prior to their doh and that S#1, S#3, S#7, S#8, S#9 and S#10 did not have a reference check. The surveyor requested the facility policy for new hire process.

On 7/16/24 at 01:29 PM, in the presence of the survey team, the US FOIA (B) (6) stated that the facility did not have a policy for the new hire process.

On 7/16/24 at 02:02 PM, in the presence of the survey team and US FOIA (B) (6) the

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F 607	Continued From page 10 US FOIA (B)(7) stated that sometimes the doh was not the date the employee started in the facility. A review of the facility provided policy titled, "Abuse Prevention Program" with a reviewed/revised date of 02/2024, included the following: 1. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has: a. Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; b. Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or c. Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The facility did not provide any additional information. N.J.A.C. 8:39-9.3 (a)4,(b); 43.15(a)	F 607		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument.	F 636		7/29/24

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A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i)

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MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 636	Continued From page 12 through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete the Comprehensive Assessment in accordance with the Resident Assessment Instrument (RAI) for three (3) of 39 residents reviewed for comprehensive assessments (Residents #6, #14, and #135). This deficient practice was evidenced by the following: Reference: The Centers For Medicare and Medicaid (CMS) RAI Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the Minimum Data Set (MDS). The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. At a minimum, facilities are required to complete a comprehensive assessment for each resident within 14 calendar days after admission to the facility and not less than once every 12 months while a resident, where 12 months refers to a period within 366 days.	F 636	1. The facility cannot retroactively correct the deficiency as it relates to Resident #6, Resident #135, or Resident #14. 2. All residents have the potential to be affected. 3. The administrator educated the [redacted] on the importance of completing comprehensive assessments in a timely manner per regulation and the correct process for comprehensive assessments. Process reviewed and affirmed understanding and able to verbalize the process. 4. The MDS coordinator /designee will audit 5 assessments per week x 4 weeks and then monthly x 2 to ensure comprehensive assessments are completed in a timely manner per regulation. The findings of these audits will be reported to the monthly QAPI meeting	

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F 636	Continued From page 13	F 636		

The MDS completion date for an annual assessment must be no later than 14 days after the ARD (ARD + 14 calendar days).

1. The surveyor reviewed the system selected MDS over 120 days for late submissions and revealed the following:

A review of Resident #6's annual (comprehensive) MDS with an ARD of [NJ ex order 26.4] revealed that the MDS was completed on [NJ ex order 26.4] and was submitted and accepted on [NJ ex order 26.4].

A review of Resident #135's annual MDS with an ARD of [NJ ex order 26.4b1] was completed on [NJ ex order 26.4b1] and was submitted and accepted on [NJ ex order 26.4b1].

Further review of the above annual MDS showed that Resident #6's MDS was completed 32 days after the ARD and Resident #135 MDS was completed 15 days after the ARD. Both MDS of Residents #6 and 135 were not completed no later than 14 days after the ARD.

On 7/12/24 at 8:56 AM, the surveyor interviewed the part-time [US FOIA (B) (6)] [US FOIA (B) (6)] The [US FOIA (B) (6)] informed the surveyor that the facility follows the RAI Manual for completing the comprehensive MDS and that the completion date was no later than 14 days from ARD.

On that same date and time, the surveyor notified the [US FOIA (B) (6)] of the above findings and concerns. The [US FOIA (B) (6)] stated, "I think it was the same issue from the last survey of late submission of MDS and we tried our best."

2. A review of Resident #14's annual MDS with an ARD of [NJ ex order 26.4] revealed that the MDS was

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F 636	Continued From page 14 completed on [NJ ex order 26.4b] and was submitted and accepted on [NJ ex order 26.4b]. Further review of the above MDS of Resident #14 showed that the MDS was completed 31 days after the ARD. MDS of Resident #14 was not completed no later than 14 days after the ARD. On 7/15/24 at 11:53 AM, the survey team met with [US FOIA (B) (6)] and [US FOIA (B) (6)]. The surveyor notified the facility management of the above findings. The [US FOIA (B)] stated that the [US FOIA (B)] acknowledged the concern with late completion and submissions of MDS. On 7/16/24 at 02:11 PM, the survey team met the [US FOIA (B) (6)] and [US FOIA (B) (6)] for an Exit Conference. The facility did not provide additional information and did not refute the findings. NJAC 8:39-11.1, 11.2(e)(h)	F 636		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete a quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 638	1. The facility could not retroactively correct the deficiency as it relates to Resident #6 or Resident #135.	7/29/24

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F 638	Continued From page 15 management of care, for two (2) of two (2) residents, Resident #6 and #135, system selected for MDS over 120 days and was evidenced by the following: Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual classified the Observation (Look Back) Period as the time period over which the resident's condition or status was to be captured by the MDS. The Assessment Reference Date (ARD) referred to the last day of the observation (or "look back") period that the assessment covered for the resident. The Quarterly assessment was considered timely if 1). The Assessment Reference Date (ARD) of the Quarterly MDS (QMDS) was within 92 days after the ARD of the previous MDS and; 2). the completion date was no later than 14 days after the ARD. 1. Resident #6's ARD was on [redacted], the quarterly assessment was not completed until [redacted], 19 days later, and was submitted [redacted] 2. Resident #135's ARD was on [redacted], the quarterly assessment was not completed until [redacted], 26 days later, and was submitted [redacted]. Resident #135's ARD was on [redacted], the quarterly assessment was not completed until [redacted], 17 days later, and was submitted on [redacted]. On 7/12/24 at 8:56 AM, the surveyor interviewed the part-time [redacted] The [redacted] informed the surveyor that the	F 638	2. All residents have the potential to be affected. 3. The [redacted] educated the [redacted] on the importance of completing quarterly assessments in a timely manner per regulation and the correct process for completing quarterly assessments. Process reviewed and affirmed understanding and able to verbalize the process. 4. The MDS coordinator /designee will audit 5 assessments per week x4 weeks and then every 2 weeks x 2 months to ensure quarterly assessments are completed in a timely manner per regulation. The findings of these audits will be reported to the monthly QAPI meeting	

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F 638	Continued From page 16 facility follows the RAI Manual for completing the quarterly MDS and that the completion date was no later than 14 days from ARD. On that same date and time, the surveyor notified the US FOIA (B) (6) of the above findings and concerns. The US FOIA (B) (6) stated, "I think it was the same issue from the last survey of late submission of MDS and we tried our best." On 7/15/24 at 11:53 AM, the survey team met with the US FOIA (B) (6) and US FOIA (B) (6) The surveyor notified the facility management of the above findings. The US FOIA (B) stated that the US FOIA (B) r acknowledged the concern with late completion and submissions of MDS. On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6) and US FOIA (B) (6) for an Exit Conference. The facility did not provide additional information and did not refute the findings. NJAC 8:39-11.1	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on the interview, record review, and review of pertinent facility documentation it was	F 641	1. The facility could not retroactively correct the deficient practice as it relates to Residents 135, 138, and 198.	7/29/24

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F 641	Continued From page 17 determined that the facility failed to accurately code the Minimum Data Set (MDS) for three (3) of the 38 residents reviewed, Residents #135, #138, and #198. This deficient practice was evidenced by the following: 1. The surveyor reviewed the system selected resident for MDS discrepancy and revealed the following: The Admission Record (AR, an admission summary) showed that the resident was admitted to the facility with the diagnosis that included but was not limited to NJ Exec Order 26.4b1 [redacted]), NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted] A review of Resident#135's Quarterly MDS (QMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ ex order 26.4b1 showed in Section NJ Exec Order 26.4b1 a brief interview for mental status (BIMS) score of NJ ex [redacted] out of 15 which indicated that the resident's NJ ex order 26.4b1. The QMDS NJ ex order 26.4b1 Section NJ Exec Order 26.4b1 showed that the assessment was done by per diem US FOIA (B) (6) [redacted] The US FOIA (B) (6) interviewed the resident if the resident had NJ Exec Order 26.4b1 and the resident responded NJ ex order [redacted]	F 641	2. All residents have the potential to be affected. 3. The facility policy was updated to specify that fully remote MDS coordinators may not complete or sign interview sections of the MDS. The Administrator educated the US FOIA (B) (6) on the updated facility policy. Policy reviewed and affirmed understanding and able to verbalize the process. 4. The MDS coordinator /designee will audit 3 assessments per week x 4 weeks and then every 4 weeks x 2 months to ensure interview sections of the MDS have been completed in-person by an appropriate staff member. The findings of these audits will be reported to the monthly QAPI meeting	

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Further review of the above QMDS [NJ Exec Order 26] revealed that the [US FOIA (B) (6)] signed and completed Section [NJ] on [NJ Exec Order 26] at 6:28 PM.

On 7/15/24 at 9:51 AM, the surveyor interviewed the [US FOIA (B) (6)] The [US FOIA (B) (6)] stated that the [US FOIA (B) (6)] works [NJ Exec Order 26.4b1], which meant that the [US FOIA (B) (6)] does not go to the facility to assess and see the resident. The [US FOIA (B) (6)] further stated that the [US FOIA (B) (6)] does all computer work [NJ Exec Order 26.4] and acknowledged that the [US FOIA (B) (6)] does not talk to the resident. The [US FOIA (B) (6)] also stated that the [US FOIA (B) (6)] was responsible for answering the MDS for Sections B, GG, H, I, J, L, M, N, and part of Sections A and O.

On that same date and time, the surveyor asked the [US FOIA (B) (6)], how the [US FOIA (B) (6)] was able to accurately answer the questions in Section [N] of the MDS if the [US FOIA (B) (6)] was not at the facility to interview the resident. The [US FOIA (B) (6)] initially did not respond and later on, stated that she [US FOIA (B) (6)] was the one who interviewed the residents for Section [NJ E]. The surveyor then asked the [US FOIA (B) (6)], if she was the one who interviewed the resident for Section [N], why the [US FOIA (B) (6)] did not sign and complete Section [NJ E]. The [US FOIA (B) (6)] stated and acknowledged that it was considered inaccurate MDS because the [US FOIA (B) (6)] did not interview the resident.

On 7/15/24 at 11:53 AM, the survey team met with the [US FOIA (B) (6)] and [US FOIA (B) (6)]). The surveyor notified the facility management of the concern regarding Resident # 135's inaccurate MDS for Section [N] of ARD [NJ ex order 26.4] done by

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US FOIA (B) (6) who did not come to the facility to interview the resident as confirmed by the US FOIA (B) (6)

On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6), US FOIA (B) (6) and US FOIA (B) (6) for an Exit Conference. The facility did not provide additional information and did not refute the findings

Reference: The Centers for Medicare and Medicaid (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, SECTION J: HEALTH CONDITIONS
Intent: The intent of the items in this section is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the management of pain, the presence of pain, pain frequency, effect of pain on sleep, and pain interference with therapy and day-to-day activities. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, falls, prior surgery, and surgery requiring active SNF (Skilled Nursing Facility) care.

According to the J0300-J0600: Pain Assessment Interview:
Planning for Care
o Directly asking the resident about pain rather than relying on the resident to volunteer the information or relying on clinical observation significantly improves the detection of pain.
o Resident self-report is the most reliable means for assessing pain.

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o Pain assessment provides a basis for evaluation, treatment need, and response to treatment.
o Assessing whether pain interferes with sleep or activities provides additional understanding of the functional impact of pain and potential care planning implications.
o Assessment of pain provides insight into the need to adjust the timing of pain interventions to better cover sleep or preferred activities ...
2. The surveyor reviewed the hybrid (paper and electronic health record) of Resident #138 which revealed the following:

The resident's AR revealed that Resident #138 had diagnoses that NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1

A comprehensive MDS, with an ARD of [redacted], under section [redacted] "NJ ex order 26.4b1" and [redacted] "NJ ex order 26.4b1" it was coded that the resident "2. [redacted]." Under Section [redacted], "Should Brief Interview for Mental Status [redacted]" it was coded [redacted]." Under Section [redacted] "Special Treatments, Procedures, and Programs," the resident [redacted]

A QMDS with an ARD of [redacted], under section [redacted], NJ ex order 26.4b1" and [redacted], "Ability to Understand Others." [redacted] "Should Brief interview for Mental Status" documented [redacted] NJ ex order 26.4b1 [redacted]" Under Section [redacted] "Special Treatments, Procedures, and Programs," the resident was not coded as NJ ex order 26.4b1

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care.

A review of the Order Summary Report included a physician's order dated [NJ ex order 26.4b] read, "Admitted to [Company Name] NJ ex order 26.4b1

On 7/10/24 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6) about completing MDS assessments' section B and section C. The US FOIA (b)(6) stated that if a resident was coded as being able to NJ ex order 26.4b1" in Section B, a BIMS should be attempted for a resident in Section [NJ E]. The surveyor reviewed with the MDSC/RN Resident #138's MDS assessments. The surveyor discussed the concern of hospice care not being coded for the resident and the inconsistency of section B and section C coding for the resident. The MDSC/RN stated she would review and provide further information.

On that same date and time, the MDSC/RN informed the surveyor the MDS assessments were modified to reflect the resident had NJ ex order 26.4b1 NJ ex order 26.4b1 and acknowledged it should have coded at the time the assessment was done.

Furthermore, the US FOIA (B) (6) stated for sections [NJ] and [NJ E] that two different staff had completed each section at different times. The US FOIA (B) (6) added that the staff who completed section [NJ] was [NJ Exec Ord] in the resident's NJ Exec Order 26.4b1. The surveyor asked about [NJ Exec Order 26.4b1] for the resident with staff who did not NJ Exec Order 26.4b1 and if a BIMS should have been attempted as the resident was coded as sometimes understood in Section [NJ E]. She stated the resident's [NJ ex order 26.4b1] and was different when interviewed by both staff. The US FOIA (B) (6) provided no further response.

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On 7/12/24 at 10:37 AM, the surveyor notified the US FOIA (B)(7 and US FOIA (B of the above concerns for Resident #138's MDS coding accuracy. There was no additional information provided by the facility.

A review of the latest version of the CMS - RAI 3.0 Manual (updated October 2023), Chapter 3-page C-2, under C0100 Coding Instructions read: " ...Code 0, no: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available... Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available."

3. The surveyor reviewed Resident #198's medical record including the MDS which revealed the following discrepancy:

According to the AR, Resident #198 was admitted to the facility with the diagnoses that NJ ex order 26.4b1 [redacted] and NJ ex order 26.4b1

A review of Resident #198's QMDS with an ARD of NJ ex order 26.4b showed in Section NJ E a BIMS score of NJ ex out of 15 which indicated that the resident's NJ Exec Order 26.4b NJ ex order 26.4b1.

The QMDS NJ ex order 26.4b Section NJ showed that the

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F 641	Continued From page 23 assessment was done by US FOIA (B) (6). The US FOIA (B) (6) interviewed the resident if the resident had NJ Exec Order 26.4b1 and the resident responded [redacted] and that the [redacted] Further review of the above QMDS [redacted] revealed that the US FOIA (B) (6) signed and completed Section [redacted] on [redacted] at 11:45 PM. NJAC 8:39-11.2(e)(1,2)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint: NJ#169038 Based on the interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) follow the physician's orders for one (1) of 38 residents, Resident #106, with regard to medications with parameters, and b.) NJ Exec Order 26.4b1 for a [redacted] medication [redacted] for one (1) of one (1) resident, Resident #316 reviewed for NJ Exec Order 26.4b1 according to standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse	F 658	1. Supplemental documentation was added to the NJ ex order 26.4b1 for Resident 106 to NJ ex order 26.4b1 [redacted]. The US FOIA (b)(6) was verbally educated by Director of Nursing for medications with parameters. The facility could not retroactively correct the deficiency as it relates to Resident 316 due to resident NJ ex order 26.4b1 [redacted] 2. All residents with orderw with parameters or site of application have the potential to be affected.	7/29/24

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F 658	Continued From page 24 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 wellbeing, 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." 1. On 7/09/24 at 11:10 AM, the surveyor reviewed the closed medical records of Resident #106 and revealed the following: Resident #106's Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that NJ ex order 26.4b1 [redacted]	F 658	3. The Director of Nursing/ designee re-educated licensed staff on medication administration: concentrating on parameters and application sites. 4. The Director of Nursing /designee will 3 residents / week x 4 weeks and then every 4 weeks x 2 months to ensure medications with parameters and application sites are included in the order. The findings of these audits will be reported to the monthly QAPI meeting	

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F 658	Continued From page 25	F 658		

NJ ex order 26.4b1 [redacted]

The most recent comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ ex order 26.4b1 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15, which indicated the resident NJ ex order 26.4b1 [redacted]

A review of the Order Summary Report (OSR) for NJ ex order 26.4b1 reflected a physician's order (PO) with an order date of NJ ex order 26.4 for NJ ex order 26.4b1 [redacted]

The above orders for NJ ex order 26.4b1 were plotted in the electronic Medication Administration Record (eMAR) for NJ ex order 26.4b1 and were administered by nurses from NJ ex order 26.4b1 at 8:00 AM. There were no NJ Exec O and NJ Exec Ord documented in the NJ ex order 26.4b1 eMAR when the medication (med) NJ ex order 26.4b1 .

On 7/10/24 at 11:41 AM, the surveyor interviewed the US FOIA (B) (6) in the NJ Exec unit. The surveyor asked the US FOI what was the facility's practice with regard to residents with orders for NJ Exec Order 26.4b1 medications (meds) with parameters. The US FOIA stated that she checked NJ ex order 26.4b1 first NJ ex order 26.4b1 and documented it in the eMAR as ordered.

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F 658	Continued From page 26 At that same time, the surveyor notified the US FOIA of the above findings that on NJ ex order 26.4b1 and NJ ex order 26.4b Resident #106's NJ ex order 26.4b1 was administered and there was no NJ Exec O and NJ Exec Ord documented as ordered. The US FOIA admitted that she was the nurse on NJ ex order 26.4b1, and NJ ex order 26.4b who administered the med while the US FOIA checked the electronic record. She further stated that she did not know why there was no documented NJ Exec O and NJ Exec Ord on those days. On 7/10/24 at 12:20 PM, the surveyor notified the US FOIA (B) (6) regarding the above findings. On 7/12/24 at 10:27 AM, the survey team met with the US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B). The surveyor notified the facility management of the above findings and concerns. On 7/15/24 at 11:53 AM, the survey team met with US FOIA (B) (6) and US FOIA (B). The US FOIA (B) stated that the med parameter order should be followed by the nurses. 2. According to the AR, Resident #316 was admitted to the facility with a diagnosis that NJ ex order 26.4b1 . The CMDS with an ARD of NJ ex order 26.4b, reflected that Resident #316 scored a NJ ex out of 15 on the BIMS which indicated that the resident NJ ex order 26.4b1 . Further review of the MDS reflected that the resident NJ ex order 26.4b1 .	F 658		

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F 658	Continued From page 27 The OSR revealed a PO with a start date of [redacted] for NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted]. Further review of the above order for [redacted] showed that the PO did not include the order for where to apply the [redacted]. On 7/10/24 at 9:15 AM, the surveyor interviewed the [redacted] who stated that she had been employed by the facility since [redacted]. The [redacted] stated that if the resident was ordered NJ ex order 26.4b1 then a location for NJ ex order 26.4b1 should be specified in the order to assure that the correct [redacted] was being treated. The [redacted] confirmed that the NJ ex order 26.4b1 ordered [redacted], was not a complete order and did not specify where on the body the NJ ex order 26.4b1 At that same time, the [redacted] explained that the only way a nurse would know where to apply the [redacted] was to ask the resident or read the resident's medical history. On 7/15/24 at 11:53 AM, the survey team met with the [redacted] and [redacted]. The surveyor notified the facility management of the above findings. On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6) [redacted] and US FOIA (B) (6) [redacted] for an Exit Conference. The facility did not provide any additional information and did not refute the findings. NJAC 8:39-11.2(b)	F 658		

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F 661	Continued From page 28	F 661		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on the interview, record review, and review of pertinent documents it was determined that the facility failed to ensure a resident was provided with an accurate discharge summary at the time of discharge, including a documented medication reconciliation, post-discharge	F 661	1. The deficient practice could not be corrected for Resident #106 since the resident NJ ex order 26.4b1 from the facility. The US FOIA (B) (6) was verbally educated by Director of Nursing for discharge summary reconciliation and	7/29/24

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F 661	Continued From page 29 instructions, and physician's prescription per the facility policy. The deficient practice occurred for one (1) of one (1) closed records reviewed (Resident #106) for appropriate discharge. This deficient practice was evidenced by the following: On 7/09/24 at 11:10 AM, the surveyor reviewed the closed medical records of Resident #106 and revealed the following: Resident #106's Admission Record (an admission summary) reflected that the resident was admitted to the facility with NJ ex order 26.4b1 [redacted]. The most recent comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident had [redacted]. The CMDS Section [redacted] Participation in Assessment and Goal Setting included that the resident's overall goal plan was to NJ ex order 26.4b1 [redacted]. A review of the Order Summary Report (OSR) for	F 661	accuracy. 2. All residents discharging have the potential to be affected. 3. The discharge process was updated to include reconciliation between physician scripts and order listing report. Licensed nursing staff were educated on the updated process. 4. The Director of Nursing /designee will audit 1 discharge chart per week x 4 weeks and then every 4 weeks x 2 months to ensure discharge medications are reconciled and accurate. The findings of these audits will be reported to the monthly QAPI meeting	

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F 661	Continued From page 30	F 661		

NJ ex order 26.4b1 reflected a physician's order (PO) with an order date of NJ ex order 26.4b for the resident's NJ ex order 26.4b1

The Discharge Instructions and Summary with a lock date of NJ ex order 26.4b revealed a list of medications (meds) that included but NJ ex order 26.4b1

The latest US FOIA (b)(6) PN dated NJ ex order 26.4b showed that the resident was continued on NJ ex order 26.4b1 y. The NJ ex order 26.4b US FOIA (b)(6) PN also included the plan to d/c the resident NJ ex order 2

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A review of the handwritten prescription (Rx) of meds dated NJ ex order 26.4b and signed by the US FOIA (b)(6) included the NJ ex order 26.4b1 by NJ ex order 26.4b1

On 7/10/24 at 11:41 AM, the surveyor interviewed RN#2 in the NJ Ex unit. The surveyor notified the US FOIA of the above concern regarding the discrepancy between the NJ ex order 26.4b1 and Summary NJ ex order 26.4b1 while the Rx handwritten and signed by the US FOIA (b)(6) including the US FOIA (b)(6) PN listed NJ Exec O NJ ex order 26.4b1

On that same date and time, RN#2 stated that Discharge Instructions and Summary were the ones the resident or family member brings home as a copy of meds and follows. The surveyor asked the US FOIA what should the nurse do if there were NJ ex order 26.4b1

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F 661	Continued From page 31	F 661		

Instructions Summary med list and Rx that was provided by the US FOIA (b)(6) and what the US FOIA (b)(6) documented in PN. The US FOIA stated that the nurse should have called the US FOIA (b)(6) and clarified the order.

On 7/10/24 at 12:20 PM, the surveyor notified the US FOIA (B) (6) regarding the above findings.

On 7/10/24 at 12:31 PM, the surveyor interviewed and notified the US FOIA (b)(6) of the above findings. The US FOIA (b)(6) confirmed that she provided the Rx on NJ ex order 26.4b1. She further stated that the resident should take the NJ ex order 26.4b1.

On 7/12/24 at 10:27 AM, the survey team met with the US FOIA (B) (6) and US FOIA (B). The surveyor notified the facility management of the above findings and concerns.

On 7/15/24 at 11:53 AM, the survey team met with US FOIA (B) and US FOIA (B). The US FOIA (B) stated that she provided in-service regarding meds reconciliation. The US FOIA (B) further stated that the nurse should have reconciled the d/c Rx and current order summary.

A review of the facility's Discharge Summary and Plan with a reviewed/revised date of NJ ex order 26.4b1 that was provided by the US FOIA (B) revealed in the Policy Interpretation and Implementation #2. The d/c summary will include a recapitulation of the resident's stay at the facility and a final summary of the resident's status at the time of the d/c in accordance with established regulations governing the release of resident information and

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F 661	Continued From page 32 as permitted by the resident. The d/c summary shall include a description of the resident's:... m. med therapy (all prescription and over-the-counter meds taken by the resident including dosage, frequency of administration, and recognition of significant side effects that would be most likely to occur in the resident). ....#3. As part of the d/c summary, the nurse will reconcile all pre-discharge med with the resident's post-discharge meds. The med reconciliation will be documented. .... On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6) and US FOIA (B) (6) for an Exit Conference. The facility did not provide additional information and did not refute the findings.	F 661		
F 684 SS=D	NJAC 8:39-36.1(b)(c) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to ensure a.) that the unwitnessed fall investigation included a	F 684	1. Resident #227's care plan was reviewed by the interdisciplinary team. 2. All residents have the potential to be	7/29/24

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F 684	Continued From page 33 conclusion for root cause analysis and b.) a new non pharmacological intervention was implemented after NJ Ex Order 26.4b for one (1) of three (3) residents reviewed NJ Ex Order 26.4 (Resident #227) according to standards of clinical practice and facility's policy and procedure. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a 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 wellbeing, 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." On 7/08/24 at 12:07 PM, the surveyor observed Resident #227 NJ ex order 26.4b1 in the	F 684	affected. 3. A new risk management software was implemented with feature requiring a root cause analysis and conclusion prior to closing out incidents. Licensed nursing staff were educated about the need to attempt non-pharmacologic interventions prior to initiating pharmacologic interventions for fall management. 4. The Director of Nursing /designee will audit 2 incidents per week x 4 weeks and then every 4 weeks x 2 months to ensure a root cause analysis and conclusion was completed for each incident and non-pharmacologic interventions are attempted as appropriate. The findings of these audits will be reported to the monthly QAPI meeting	

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dayroom being fed lunch.

The surveyor reviewed Resident #227's medical record.

The Admission Record (or face sheet; admission summary) indicated that the resident was admitted to the facility with medical diagnoses that included but were not limited to; NJ ex order 26.4b1 [redacted]

Resident #227's most recent quarterly Minimum Data Set (MDS) and initial admission MDS, an assessment tool used to facilitate the management of care, indicated that the resident's NJ ex order 26.4b1 [redacted] .

The individualized Care Plan (CP) reflected a focused area with an initiated date of [redacted], of Resident #227 NJ ex order 26.4b1 [redacted] Interventions included: anticipate and meet resident's needs; follow facility [redacted] keep call light within reach, encourage use and answer promptly; keep personal items within reach; provide a safe environment; upon return from hospital: Room to be closer to nursing station.

Further review of Resident #227's CP reflected an additional focus area had an [redacted] which listed several dates that the resident [redacted]

On 7/09/24 at 11:38 AM, the surveyor interviewed the US FOIA (B) (6) [redacted] regarding the

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process for a [redacted]. The [redacted] stated that the supervisor would be notified and resident would be assessed and if it was NJ Exec Order 26.4b1 [redacted] would be performed. She added that she would initiate an incident report and an investigation would be done. The [redacted] stated that an intervention would be put in place to try to prevent another [redacted] and that the US FOIA (B) (6) would place it on the care plan.

On 7/09/24 at 12:52 PM, the surveyor requested from the US FOIA (B) (6) [redacted] any incident/investigation for Resident #227.

On 7/10/24 at 9:05 AM, the surveyor reviewed the facility provided incident investigations for [redacted] which included the following:

NJ ex order 26.4b1 [redacted]: Nursing Description: NJ ex order 26.4b1 [redacted]. There was no documented conclusion of the investigation for the root cause of the [redacted]. Attached to the incident report was a copy of the care plan with the following updated intervention: [redacted] Recreation screen for diversional activities with an initiated date of [redacted].

NJ ex order 26.4b1 : Nursing Description: while resident in the day room, eating breakfast he/she slid out of NJ ex order 26.4b1 and [redacted]. Other Info included resident slid out of chair. Attached to the incident report was a copy of the care plan with the following updated intervention: [redacted]: NJ ex order 26.4b1 [redacted]

NJ ex order 26.4b1 Nursing Description: during afternoon med pass (medication

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F 684	Continued From page 36 administration for the unit), writer heard a [redacted], when writer looked in the direction of the day room resident NJ ex order 26.4b1 [redacted]. There was no documented conclusion of the investigation for the root cause of the [redacted] Attached to the incident report was a copy of the care plan with the following updated interventions: 1. NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] e intervention which is not primarily based on medication) implemented to attempt to prevent an additiona[redacted] NJ ex order 26.4b1 : Nursing Description: around 11:15 PM, while aid was doing rounds, resident observed on NJ Exec Order 26.4b1 [redacted] There was no documented conclusion of the investigation for the root cause of the [redacted]. Attached to the incident report was a copy of the care plan with the following updated intervention: [redacted]: NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 at bedtime with an initiated date of [redacted]. Also attached to incident documentation was a nursing progress note with an effective date of [redacted] that was created on [redacted] (a late entry) which included the following: consulted with [redacted] about resident NJ ex order 26.4b1 [redacted], advised for staff to use PRN NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] There was no npi implemented to attempt to prevent an additional [redacted] There was not a different intervention implemented, the same intervention that was implemented after the last [redacted] was used again.	F 684		

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On 7/10/24 at 10:33 AM, the surveyor interviewed the US FOIA (B) (6) of US FOIA (b)(6) regarding the process for a [redacted]. The [redacted] stated that the process for a NJ Exec Order 26.4b1 was to interview aids, nurses and the resident and write an incident report which was given to the US FOIA (B) (6) [redacted] and US FOIA (B) (6) US FOIA (B) (6) She added that an investigation was done by the team and a conclusion or root cause was done by the [redacted] and [redacted]. The [redacted] stated that for an unwitnessed fall the difference would be that the team would try to figure out what the resident was doing at the time of the [redacted] She added that the team has a huddle at 2 PM and would discuss what a good intervention was to be put in place to prevent another [redacted]

On 7/10/24 at 10:46 AM, the surveyor interviewed the [redacted] regarding the process for an NJ Exec Order 26.4b1. The [redacted] stated that for a [redacted] after assessment, and notifications and administration of any orders, an incident report was initiated by the nurse. She added that she and the [redacted] with the help of the unit manager would do an investigation and a conclusion would be done in the computer. She then stated that for an NJ Exec Order 26.4b1 there was no conclusion just an intervention on the care plan. The [redacted] stated that a new intervention would be implemented after each fall on the care plan. She added that they would look at the prior intervention and add a new intervention to prevent fall. The surveyor asked about a psych consult being an intervention for a [redacted] The [redacted] stated that if a resident was NJ Exec Order 26.4b1 [redacted] then they would do a NJ Exec Order 26.4b1. She added that NJ Exec Order 26.4b1 and that if that did not work then a pharmacological intervention

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would be done.

On 7/10/24 at 11:13 AM, the surveyor interviewed the [redacted] regarding the process for [redacted]. The [redacted] stated that after nurse assessment, notifications and following physician orders, the nurse would initiate an incident report. She added that it included a description of the event and factors that contribute to the event. She added that there was space for additional information that may contribute to the root cause. The surveyor asked if there was a conclusion. The [redacted] stated that there was a summary of the reason. The interview had to be paused.

On 7/11/24 at 12:12 PM, the surveyor interviewed the [redacted] regarding Resident #227 [redacted] and interventions that were implemented on the care plan. The [redacted] stated that a [redacted] was an intervention and that the consult was for a medication (med) adjustment or sometimes ask for a med, look at CP. The surveyor asked if a [redacted] was implemented. The [redacted] stated that the [redacted] was a [redacted] for med review when a med can cause a [redacted] and the med could be changed. The surveyor then asked the [redacted] about the [redacted] intervention which was a [redacted]. The [redacted] stated that she needed to review the resident's record.

On 7/11/24 at 12:29 PM, the [redacted] stated that for the [redacted] the intervention was a [redacted] and the recommendation was to encourage staff to use the prn med which was maybe [redacted] for NJ ex order 26.4b1. The [redacted] then stated that for the [redacted] the intervention was to be seen [redacted] and the recommendation was to discontinue the prn med and to make the [redacted] a standing order for qid

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(four times a day).

On 7/11/24 at 12:45 PM, the surveyor interviewed the [redacted]. The [redacted] stated that on the incident report there were contributing factors and additional information and they look for a cause which helps to identify preventative measures. She added there was a discussion to review the incident and all contribute to a conclusion on preventing a reoccurrence. The [redacted] stated [redacted] the attachments to the incident report were supporting documents for the incident report and that the care plan was attached with the intervention that was implemented. The surveyor asked the [redacted] about the [redacted] and the intervention of psych consult and if a [redacted] was put in place. The [redacted] stated that [redacted] The surveyor then asked the [redacted] about the [redacted] and the same intervention of psych consult and if a [redacted] was put in place. The [redacted] stated that a [redacted] was an intervention and that it was a [redacted] since it could be a med review for a possible GDR (gradual dose reduction). She then added that the [redacted] could recommend [redacted] The surveyor asked the [redacted] if the [redacted] made any [redacted] recommendations. The [redacted] stated that she would have to check.

On 7/12/24 at 10:07 AM, the surveyor interviewed the [redacted]. The [redacted] stated that the interdisciplinary team (IDT) would meet in morning meeting to discuss a resident's [redacted] but that they do not document the meeting. She added that when they get together to review a [redacted] the team discusses [redacted] and diversional activities and that moving forward will document the discussion.

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F 684	Continued From page 40 On 7/12/24 at 10:49 AM, in the presence of the survey team, the surveyor notified the [redacted] and the concern that Resident #227's [redacted] did not have a conclusion for the root cause or IDT meeting documented and that the last [redacted] did not have an additional [redacted] intervention added and that both interventions were a NJ ex order 26.4b1 On 7/15/24 at 12:00 PM, in the presence of the survey team and [redacted], the [redacted] stated that a [redacted] option was added to include a [redacted] order to reflect [redacted] The [redacted] confirmed that there was not a [redacted] added after the [redacted] The facility did not provide any additional information. A review of the facility provided policy titled, "Accidents and Incidents-Investigating and Reporting" with a reviewed/revised date of 01/2024, included the following: Policy Statement All accidents or incidents involving resident, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation 1. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. 2. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time the accident or incident took place; ...	F 684		

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F 684	Continued From page 41 c. The circumstances surrounding the accident or incident; d. Where ... k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. .. The policy did not include information about a conclusion or root cause analysis or documentation about an interdisciplinary team meeting or discussion. A review of the facility provided policy titled, "Managing Falls and Fall Risk" with a reviewed/revised date of 01/2024, included the following: Policy Statement Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk ... 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling, or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature	F 684		

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F 684	Continued From page 42 or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable .... Monitoring Subsequent Falls and Fall Risk 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling. 2. If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the intervention (e.g., dizziness or weakness) has resolved. 3. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. 4. The staff and/or physician will document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls. N.J.A.C. 8:39-27.1 (a)	F 684		
F 689 SS=H	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		8/9/24

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F 689	Continued From page 43 Complaint number #169038 Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to a.) timely assess a resident after the resident had an NJ ex order 26.4b1 on NJ ex order 26.4b at 01:20 AM. Subsequently, the resident NJ ex order 26.4b1 at 11:54 AM, with a diagnosis of NJ ex order 26.4b1 and NJ ex order 26.4b1 b.) NJ ex order 26.4b NJ ex order 26.4b1 ; c.) failed to report the NJ ex order 26.4b to the New Jersey Department of Health (NJDOH). This deficient practice was identified for one (1) of five (5) residents (Resident #316) reviewed for accidents and was evidenced by the following: Review of the Admission Record (an admission summary), indicated Resident #316 was admitted to the facility with a diagnosis that included but was not limited to; NJ ex order 26.4b1 Review of the nursing progress note (PN) dated NJ ex order 26.4b at 18:40 (6:40 PM), reflected that Resident #316 was admitted to the facility NJ ex order 26.4b Review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of resident care dated NJ ex order 26.4b, reflected that Resident #316 scored a NJ ex out of 15 on the Brief Interview for Mental Status (BIMS) which indicated that the resident was NJ ex order 26.4b1 NJ ex order 2. The MDS also reflected that the resident	F 689	1. The facility cannot retroactively correct the deficiency as it relates to Resident # 316 since the resident [redacted] at the facility. 2. All residents have the potential to be affected. 3. The Director of Nursing /designee educated licensed staff on the requirement to have a timely post-fall assessment; ongoing pain assessment and follow up with providers to ensure management of pain, as appropriate; and mandatory reportable guidance. 4. The Director of Nursing /designee will audit 2 resident charts per week x 4 weeks and then every 4 weeks x 2 months to ensure an assessment is completed timely post-fall; that pain is assessed and managed timely; and mandatory reportable guidance is adhered to. The findings of these audits will be reported to the monthly QAPI meeting	

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NJ ex order 26.4b1 during the assessment reference period and required NJ ex order 26.4b1 Further review of the MDS reflected that the resident NJ ex order 26.4b1 and NJ ex order 26.4b1 since admission to the facility.

A review of Resident #316's Comprehensive person-centered Care Plan (CP) indicated that the resident NJ ex order 26.4b1 associated with the diagnosis of NJ ex order 26.4b1 NJ ex order 26.4b1 The interventions included the following:
-Administer NJ ex order 26.4b1 as ordered
-Monitor and record NJ Exec O characteristics every shift and prn (as needed), quality, and severity (0-10 scale). Anatomical location, onset duration, continuous, intermittent, and relieving factors.
-Monitor and Report to the nurse resident complaints of NJ ex orde or request for NJ ex order 26.4b1.
-Notify the physician if interventions were unsuccessful or if the current complaint is a significant change from the resident's past experience of NJ ex orde.
-Anticipate the resident's need for NJ Exec Order 26.4b1 and respond immediately.

Review of the electronic Medication Administration Record (eMAR) dated NJ ex order 26.4b1 indicated physician ordered NJ Exec Order 26.4b1 to be performed every shift, pain scale of NJ ex order 26.4b1 NJ Exec Order 26.4b1 of NJ ex order 26.4b1, NJ Exec Order 26.4b1 of NJ ex order 26.4b1, and NJ Exec Order 26.4b1 of NJ ex order 26.4b1
Non-pharmacological interventions to be administered prior to prn meds: The following codes were to be documented on the eMAR:
1-NJ ex order 26.4b1
2-NJ ex o

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3-NJ ex ord,
4-c NJ ex order 26.4b1
5-NJ ex order 26.4b1
6-NJ ex order 26.4b1.

Review of the Order Summary Report (OSR) showed a physician order (PO) with a start date of NJ ex order 26.4b, for NJ ex order 26.4b1

Further review of the OSR revealed a PO dated NJ ex order 26.4b, for NJ ex order 26.4b1

The PN dated 9/16/23 at 01:20 AM, indicated that around 12:00 AM, the US FOIA (B) (6) was called to Resident #316's room by the US FOIA (B) (6) The resident was observed sitting on the floor next to the bed. The resident stated that they were going to the bathroom, NJ ex order 26.4b1, and NJ ex. The US FO revealed that the US FO NJ ex order 26.4b1 and the resident NJ ex order 26.4b1 .

The surveyor reviewed the Incident and Accident investigation (IAI) dated NJ ex order 26.4b, for an NJ ex order 26.4b1 The IAI indicated that the resident was to be NJ ex order 26.4b1 for NJ ex order 26.4b1 NJ ex order 26.4b for the decrease in activities of daily NJ ex order 26.4b1, and any change in the resident's NJ Exec Order 26 or vital signs (NJ Exec Order 26.4b1 . There was no documented evidence

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on the report that the [US FO] or [NJ Exec Order 26.4b1] [redacted] department was notified that the resident had [NJ ex order 26.4] [redacted].

The [US FO] note dated [NJ Exec Order 26.] at 12:14 PM, reflected that Resident #316 had [NJ Exec Order 26.4b1] in their [NJ Exec Order 26.4b1] and stated that their [NJ Exec Or] [redacted]. There was no documented evidence that the [US FO] notified the nurse that the resident had complaints of [NJ Exec O] nor was there documentation that the [US FO] was aware that the resident had [NJ Exec Order 26.4b1].

The nursing [US FO] dated [NJ Exec Order 26.] at 14:07 (02:07 PM), indicated that the resident told the nurse that they [NJ Exec Order 26.4b1] the night before and the nurse notified the supervisor.

A review of the [US FO] dated [NJ Exec Order 26.] at 14:34 (02:34 PM), indicated that Resident #316 [NJ Exec Order 26.4b1] of [NJ Exec O] on a [NJ Exec Order 26.4b1] which indicated [NJ Exec Order 26.4b] . The nurse administered [NJ Exec Order 26.4b1] two tabs (tablets).

The [US FO] dated [NJ Exec Order 26.] at 14:53 (02:53 PM), indicated that the resident [NJ ex order 26.4b1] [redacted] by the [NJ ex order 26.4b] and the chart was to be reviewed by [NJ Exec Order 26.4b1] for a [NJ ex orde] [redacted]. There was no documented evidence that the nurse contacted the [US FOIA] [redacted] regarding the residents' complaints of [NJ Exec] that were not relieved by the [NJ ex order 26.4] . Furthermore, there was no assessment conducted when the resident began complaining of [NJ Exec O]

Review of the [US FOIA (B) (6)] [redacted] note dated [NJ ex order 26.4b] at 6:26 PM, indicated that the

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resident's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 by NJ Exec O in the NJ Exec Order 26.4 and the NJ Exec Order 26.4b1. There was no documentation that the US FO notified the nurse regarding the resident's NJ Exec Order 26.4b1, nor was there documentation that the PT was aware that the resident had previously NJ ex order 2.

The surveyor reviewed the US FOIA (B) (6) notes dated NJ ex order 26.4b1 at 12:57 PM, which indicated that Resident #316 reported NJ ex order 26.4b1 The resident NJ Exec Order 26.4b1 or any bed NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 and NJ Exe. There was no documented evidence that the US FOIA (B) notified the nurse that the resident had complaints of NJ ex order 26.4b1 and there was no documentation that the COTA was aware that the resident had NJ ex order on NJ ex order 26.4.

According to the eMAR, the resident complained of NJ ex orde on NJ ex order 26.4 on the 3-11 PM shift. The nurse documented on the eMAR that the resident complained of NJ ex orde at a NJ Exec Order 26.4b1 of NJ ex order 26.4 indicating NJ ex order 26.4b1. The documentation showed that the resident was not provided with , nor was the resident offered a NJ ex order 26.4b1. The eMAR reflected that the resident was not provided with prn NJ ex order 26.4b1.

A review of the PN dated NJ ex order 26.4 at 14:56 (02:56 PM), indicated that the resident complained of NJ ex NJ ex order 26.4b1 that was not relieved by NJ ex order 26.4 and the MD was aware. There were no new PO and there was no documentation that the resident was reassessed for NJ ex order 26.4b1 due to increased complaints of NJ ex orde

The PTA note dated NJ ex order 26.4 at 5:56 PM, indicated

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MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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that the resident continued to [NJ ex order 26.4b1] with all movements and even with the [NJ ex order 26.4b1]. The note indicated that the resident [NJ ex order 26.4b1]. There was no documented evidence that the [US FO] notified the nurse regarding the residents' complaints, nor was there documentation that the [US FO] was aware that the resident had [NJ ex order 26.4b1].

According to the eMAR dated [NJ ex order 26.4] on the 3-11 PM shift, the resident had [NJ Exec Order 26.4b1] at a [NJ Exec Order 26.4b1] of [NJ ex] which indicated [NJ ex order 26.4b1], and was offered [NJ ex order 26.4b1]. There was no documented evidence that [NJ ex order 26.4b1] was provided. The PN dated [NJ ex order 26.4] at 17:36 (5:36 PM), indicated that the resident [NJ ex order 26.4b1] and was ordered [NJ ex order 26.4b1].

A review of the [US FOIA] notes dated [NJ ex order 26.4] at 5:54 PM indicated that Resident #316 continued to [NJ ex order 26.4b1]. The note also revealed tha [NJ ex order 26.4b1]. The note did not contain any information that the [US FO] informed the nurse about the resident's [NJ ex order 26.4b1]. There was also no documentation that the PT was aware that the resident [NJ ex order 26.4b1] of the [NJ ex order 26.4b1].

The PN dated [NJ ex order 26.4] at 18:24 (6:24 PM) revealed that the resident was [NJ ex order 26.4b1] [NJ ex order 26.4b1] and [NJ ex order 26.4b1] the [NJ ex order 26.4b1]. The PN indicated that the [US FOI] and family were aware. No further [US FOI] orders

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F 689	Continued From page 49 or assessments were documented, and the resident was not provided with any additional prn NJ Exec Order 26.4b1 when they continued to complain of NJ Exec Or The PN dated NJ ex order 26.4 at 10:56 AM, indicated that the US FOIA (b)(6)) examined Resident #316 and documented that the resident NJ ex order 26.4b1 . There was no documentation within the note that indicated that the US FOI was aware that the resident had NJ Exec Ord or NJ ex order 26.4b1 . There was also no documented evidence that the physician was aware that the resident could not have the NJ ex order 26.4b1 . There were also no NJ ex order 26.4b1 ordered at this time and there were NJ ex order 26.4b1 . Review of the eMAR dated NJ ex order 26.4, indicated that the Resident complained of NJ ex order 26.4b1 which indicated NJ ex order 26.4b1 on NJ ex order 26.4b1 (day shift), NJ ex order 26.4b1 (evening shift) and NJ ex order 26.4b1 (night shift). The day shift and evening shift provided NJ ex order 26.4b1 however, the NJ ex order 26.4b1 At no time, on all shifts, did the resident NJ ex order 26.4b1 On 9/21/23 at 14:56 (02:56 PM), the nurse documented that the resident had complaints of NJ ex order 26.4b1 The note also indicated that the MD was aware. There were no new POs obtained for NJ ex order 26.4b1	F 689		

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The US FOIA note dated NJ ex order 26.4b at 4:28 PM, indicated that the resident had complaints of NJ ex order 26.4b1 when the US FOIA tried to move the left . There was no documented evidence that the US FOIA notified the nurse regarding the residents' complaints of NJ Exec O

The Physician's PN dated NJ ex order 26.4b1 at 12:13 PM, indicated that the US FOIA (b)(6) examined Resident #316. The US FO documented that the resident was lying in bed and had NJ ex order 26.4b1 on and off. There was no documented evidence that the US FO was aware that the resident NJ ex order 26.4b1, or that the resident did not have NJ ex order 26.4b1 NJ ex order 26.4b1.

Review of the eMAR dated NJ ex order 26.4b, for the Dayshift indicated that Resident #316 had complaints of NJ Exec Order 26.4b1 NJ ex o and was provided with NJ ex order 26.4b1 . There was no documented evidence that the US FOIA was notified of the resident's NJ ex order 26.4b1

Further review of the PN, indicated a late entry note dated NJ ex order 26.4b at 13:03 (01:03 PM) from the US FOIA (b)(6) was in to see the resident that morning that the resident agreed to take the med NJ ex order 26.4b1 and that the resident NJ ex o NJ ex order 26.4b1 The note also indicated that the resident had an active NJ ex order 26.4b1 (did not specify which one) NJ ex order 26.4b1 .

The PTA note dated NJ ex order 26.4b at 5:39 PM, indicated that the resident continued to complain of NJ ex orde in the NJ ex order 26.4b1 There was no documented evidence that the US FOIA notified the

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nurse regarding the resident's continued NJ ex order 26.4b1.

According to the eMAR, the resident had a new PO dated NJ ex order 26.4b for NJ ex order 26.4b1 The resident did not receive a PO for the NJ ex order 26.4b1 until NJ Ex days after NJ ex order 26.4b1 and NJ Exec Orde days after the resident had NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex orde

According to the US FOIA notes dated NJ ex order 26.4b , and NJ ex order 26.4b the resident continued to receive PT despite resident's NJ ex order 26.4b1

A review of the PO dated NJ ex order 26.4b, revealed an order for NJ ex order 26.4b1

A review of the NJ Exec Order 26.4b report showed that the test for NJ ex order 26.4b1 was done on NJ ex order 26.4b and was reported to the facility on NJ ex order 26.4b, with the NJ ex order 26.4b1

Review of the PN dated NJ ex order 26.4b1 at 11:54 AM, indicated that the resident had NJ ex order 26.4b and the results reflected that the resident had an NJ ex order 26.4 NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1 The US FOIA was notified, and the resident was sent to the NJ ex order 26.4b1 for NJ ex order 26.4b1

On NJ ex order 26.4b at 11:38 AM, the surveyor interviewed

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the US FOIA (B) (6) who explained that when a resident complained of NJ ex ord, the resident's NJ Exec Order 26.4b needed to be documented and the NJ ex order 26.4b1 as ordered by the US FOIA. She stated that the nurse was responsible to document the location of the NJ ex ord if the resident had NJ ex ord with NJ ex order 26.4b1 and the resident's NJ Exec Or. She stated that if the NJ ex order 26.4b1, the US FOIA should be notified and that something different should be ordered to manage the resident's NJ ex orde. She stated that if the resident still NJ ex order 26.4b1, the US FOIA and family should be notified, and the resident should be NJ ex order 26.4b1 for evaluation.

On that same date and time, the US FOIA reviewed Resident #316'2 eMAR and stated that when the resident had complained of NJ ex order 26.4b1 scale of mild NJ ex orde and that the NJ ex order 26.4b1 then the US FOIA should have been notified so that they could get the appropriate NJ Exec O med for NJ Exec Order 26.4b1 and NJ ex order 26.4b1. The US FOIA reviewed Resident #316's medical record in the presence of the surveyor and stated that if the resident NJ ex order 26.4b1, the resident NJ ex order 26

On 7/10/24 at 9:15 AM, the surveyor interviewed the US FOIA (B) (6) who stated that she had been employed by the facility NJ Exec Order 26.4b1 The US FOIA (B explained that the NJ Exec Order 26.4b1 that the facility used was the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1. The US FOIA (B stated that if Resident #316's NJ ex ord was NJ ex order 26.4b1

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per indication of the NJ ex order 26.4b1 then the staff should have notified the US FOIA for a possible change in NJ Exec Order 26.4b.

On that same date and time, the US FOIA (b)(6) reviewed the PN and stated that the staff was monitoring the resident's NJ ex order and notified the US FOIA on NJ ex order 26.4b1 She stated that she could not speak as to why a NJ ex order 26.4b was ordered or why the resident was NJ ex order 26.4b1 NJ ex order 26.4b1 She then stated that she could not speak to how the US FOIA (b) conducted their decision-making.

At that same time, the US FOIA (b) reviewed the IAI that was conducted after Resident #316 NJ ex order 26 and stated that she did include factors that contributed to the resident's NJ ex order The US FOIA (b) stated that she did not complete a summary or conclusion related to the NJ Exec and that was something she did not normally do. The US FOIA (b) stated that she did not know that if a NJ Exec Order 26 sustained during a NJ Exec had to be reported to the NJDOH. The US FOIA (b) stated that the facility followed the PO and felt that they followed protocol related to Resident #316 NJ ex order

Furthermore, the US FOIA (b) stated that the resident's NJ ex order was discussed with the nursing staff at the time of the NJ ex order, and then it was discussed with the supervisors on the coming shift. She explained that the Interdisciplinary Team (IDT) team, which consisted of the US FOIA (b) US FOIA (b)(6) US FOIA US FOIA (b)(6) US FOIA (b) , US FOIA (b)(6) , meet every day at morning meetings except weekends. She stated that if the resident NJ Exec on the weekend, then it was communicated to the US FOIA (b) by the

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US FOIA (b)(6) She stated that she was not sure why it was not determined earlier that the resident's NJ Exec Order 26.4b1 was attributed to the [redacted] that occurred on [redacted], and was not sure why the resident [redacted] med was not effective in managing [redacted] or why the resident was NJ ex order 26.4b1 [redacted] after [redacted] NJ ex order 26.4b1

On 7/10/24 at 10:05 AM, the surveyor interviewed the US FOIA (B) (6) who stated that she had been employed in the facility for NJ Exec Order 26.4b1 She stated that the treating [redacted] that treated Resident #316 from NJ ex order 26.4b1 were NJ ex order 26.4b1 in the facility. The [redacted] explained that the [redacted] evaluation was done prior to the fall on [redacted], after the evaluation was conducted on [redacted], after the resident fell. The [redacted] reviewed the documentation from both the [redacted] and [redacted] and confirmed that the therapist had documented that the resident NJ ex order 26.4b1. The [redacted] continued to review the [redacted] and [redacted] notes and confirmed that [redacted] documented that she notified the nursing staff on [redacted], regarding the resident NJ ex order 26.4b1 and that nursing was NJ ex order 26.4b1. The [redacted] could not find any additional documentation during NJ ex order 26.4b1 that the [redacted] or [redacted] notified the nursing staff that the resident continued to have NJ ex order 26.4b1 of [redacted] and NJ ex order 26.4b1 NJ ex order 26.4b1.

On that same date and time, the [redacted] stated that the evaluating and treating [redacted] did not document that they were aware that the resident NJ ex order 26.4b1 The [redacted] further stated that she could not remember that far back, however if it was not documented that the resident had a [redacted] to NJ ex order 26.4b1

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then she could not speak to why the staff did not document that they were aware of the resident's [redacted].

On 7/10/24 at 10:26 AM, the surveyor interviewed the [redacted] who confirmed that she documented on [redacted] that she provided [redacted] to Resident #316. The [redacted] stated that the resident [redacted]. The [redacted] stated that she could not remember the resident, but upon reviewing her documentation she should have been more specific in her documentation regarding notification of the [redacted] and [redacted] regarding the resident's [redacted] and [redacted].

On 7/10/24 at 10:45 AM, the surveyor interviewed the [redacted] who stated that [redacted] was usually done by the [redacted] however if Resident #316 was admitted with the diagnoses [redacted] The [redacted] stated that he could not remember if he was notified that the resident [redacted]

At that time, the [redacted] reviewed the resident's [redacted] and stated, [redacted] If the resident [redacted] He stated that he did not remember if the nurses reported to him that the resident [redacted] that [redacted] that it should have been followed up on. He stated that would have to review his notes and get back to the surveyor.

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F 689	Continued From page 56 On 7/10/24 at 11:12 AM, the surveyor interviewed the facility's US FOIA (B) (6) who stated that she could not recall if she was told by NJ Exec Order 2 or the nursing staff that the resident had NJ ex order on NJ ex order 26.4b1. She stated that if there was no documentation in her notes that she was aware that the resident had fallen, then she probably did not know that the resident NJ ex order 26.4b1. She stated that the therapist would let her know that a resident NJ ex order 26.4b1 The US FOIA (b)(6) further stated that NJ ex order 26.4b1 that the resident NJ ex order 26.4b1 e. She stated that NJ ex order 26.4 She stated that NJ ex order 26.4b1, however, when she had come in the NJ ex order 26.4b, she had ordered the resident NJ ex order 26.4b1. She continued to explain that resident care was an interdisciplinary approach and that communication was key to providing care to residents. On 7/15/24 at 11:53 AM, the survey team met with the US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B). The surveyor notified the facility management of the above findings. On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6) and US FOIA (B) (6) for an Exit Conference. The facility did not provide any additional information. A review of the facility policy titled, "Managing Falls and Fall Risk" dated 01/2024, indicated that based on previous evaluations and current data, the staff will identify interventions related to the	F 689		

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resident's specific risk and causes to try to prevent the resident from falling and try to minimize complications from falling. The policy also indicated that the staff and/or physician would document the basis for conclusions that specific irreversible risk factors exist that continue to present a risk for falling or injury due to falls.

The facility policy titled, "Pain Assessment and Management" dated 01/2024, reflected that pain management program is based on a facility-wide commitment to resident comfort. Pain management is a multi-disciplinary care process that include the following:
-Assessing the potential for pain.
-Effectively recognizing the presence of pain.
-Identifying the characteristics of pain.
-Addressing the underlying cause of the pain.
-Monitoring for effectiveness of interventions.
-Modifying approaches as necessary.
Identify the causes of pain and review the resident's clinical record to identify conditions or situations that may predispose the resident to pain including Muscular Skeletal conditions: fractures. The policy indicated that the following information was to be reported to the physician or practitioner: significant changes in the level of the resident pain and prolonged unrelieved pain despite care plan interventions.

The facility policy titled, "Accidents and Incidents-Investigating and Reporting" dated 01/2024, indicated that all accidents or incidents involving residents, employees, visitors, vendors etc., occurring on the facilities premises shall be investigated and reported to the Administrator. The policy did not specify a timeframe or documentation on reporting to the Department of Health (DOH).

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F 689	Continued From page 58 A review of the facility's Policy and Procedure: Physician Responsibilities, Signatures, and Visits with reviewed/revised date of 01/2024, that was provided by the LNHA revealed: I. Responsibilities a. General Responsibilities i. Physicians are responsible for providing comprehensive medical care to residents, including diagnosis, treatment, and ongoing management of chronic and acute conditions. ii. Physicians should ensure continuity of care by coordinating with other healthcare providers and specialists as necessary. iii. Physicians must comply with all relevant federal, state, and local regulations and adhere to the standards set by accrediting bodies. NJAC 8:39-27.1 (a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) administer	F 695	1. Resident (#111) NJ ex order 26.4b1 [redacted] Resident (#466) NJ ex order 26.4b1 [redacted] and	7/29/24

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F 695	Continued From page 59 NJ ex order 26.4b1 according to the physician's order, b.)Nj ex order 26.4b1, and Nj ex order 26.4b1. This deficient practice was identified for two (2) of two (2) residents (Residents #111 and #466) reviewed for NJ ex order 26.4b1 according to the standard of clinical practice, and the facility's policy and procedure. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and 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 wellbeing, and executing medical regimens 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."	F 695	dated. 2. All residents with respiratory equipment have the potential to be affected by this practice. 3. The DON/ designee educated the licensed nursing staff on the components of this regulation with emphasis on: Ensuring oxygen and nebulizer tubing is changed and dated appropriately and timely for residents requiring oxygen therapy and nebulizer with physicians order in place, following physician orders related to liter flow of oxygen, and storage of resident oxygen equipment. 4. The Director of Nursing /designee will conduct a weekly audit of 3 residents x4 weeks and then every 4 weeks x2 months to ensure: Residents receiving oxygen therapy and nebulizer treatments have had their oxygen tubing and nebulizer tubing changed weekly. Physician orders are in place, observation review reflects the resident□s current oxygen tubing and nebulizer tubing are changed weekly per physician□s orders and the plan of care updated and the plan of care is updated as appropriate. -The findings of these audits will be reported to the monthly QAPI meetings	

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1. During initial tour on 7/08/2024 at 10:10 AM, the surveyor observed Resident #111 sitting in the Nj ex order 26.4b1 in their room. The resident showed Nj ex order 26.4b1

According to the Admission Record (AR, an admission summary), Resident #111 was admitted to the facility Nj ex order 26.4b1 , Nj ex order 26.4b1 Nj ex order 26.4b1

The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Nj ex order 26.4b, reflected a Brief Interview for Mental Status (BIMS) score of Nj ex out of 15, which indicated that the resident Nj ex order 26.4b1.

A review of the active Physician's Orders (PO) revealed the following orders:
Nj ex order 26.4b1

Nj ex order 26.4b1

Nj ex order 26.4b1 ."

Further review of the above PO showed that

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F 695	Continued From page 61 there were no orders pertaining to changing of NJ Ex Order 26.4b1 [redacted] The above PO was transcribed to the Nj ex order 26.4b1 electronic Medication Administration Record (eMAR) for Nj ex order 26.4b1 [redacted] and the signed by nurses every shift as administered. A review of the PO did not reflect an order to change the Nj ex order 26.4b1. The electronic Treatment Administration Record (eTAR) did not reflect an order to change the Nj ex order 26.4b1 During an interview with the surveyor on 7/12/24 at 11:25 PM, the US FOIA (B) (6) [redacted] stated that the NJ Exec Order 26.4b1 [redacted] and the NJ Exec Order 26.4b1 should be changed weekly. "They (the night shift nurses) date and put their initials on it and changing the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 weekly and the PO should be reflected in the eTAR." The US FOIA (B) (6) acknowledged that it was bad that the NJ Exec Ord was there for NJ Exec Order 26.4b1, and it can cause NJ Exec Order 26.4b1 NJ Exec Order 26.4 The US FOIA (B) (6) further stated the NJ Exec Ord should be wiped off and placed back in the bag after use. On 7/12/24 at 12:42 PM, the surveyor interviewed the US FOIA (B) (6) [redacted] The US FOIA (B) stated that the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 gets changed weekly, and "That is our policy." The US FOIA (B) further stated that there was a standing order for changing the NJ Exec Order 26.4b1 and the NJ Exec Order 26.4b1 and they (the	F 695		

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nurses) document in the eTAR. The [redacted] acknowledged that [redacted]

On 7/15/24 at 12:00 PM, the survey team met with [redacted] The surveyor notified the facility management of the above findings. The [redacted] stated that the [redacted] should be changed weekly or as needed for infection control.

On 7/16/24 at 02:11 PM, the survey team met the [redacted] for an Exit Conference. The facility did not provide additional information and did not refute the findings.

2. On 7/08/24 at 11:34 AM, the surveyor observed Resident #466 lying on the bed. There was an [redacted] and was [redacted]. The resident was [redacted].

On 7/10/24 at 9:12 AM, the surveyor observed the resident inside their room with a [redacted] The resident [redacted] The resident was [redacted].

The surveyor reviewed the electronic medical records (eMR) of Resident #466 and showed the following:

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The AR reflected that the resident was admitted to the facility with diagnoses that included a Nj ex order 26.4b1 and Nj ex order 26.4b1 Nj ex orde

A review of the Comprehensive MDS (CMDS) with an assessment reference date (ARD) of Nj ex order 26.4b revealed in Section NJ Exec Order 26.4b1 a BIMS score of Nj ex which reflected that the resident Nj ex order 26.4b1. The CMDS also revealed that the resident Nj ex order 26.4b1 while a resident in the facility.

The Nj ex order 26.4b1 Order Summary Report (OSR) revealed a PO dated Nj ex order 26.4b for Nj ex order 26.4b1

The above order for NJ Exe was transcribed into the Nj ex order 26.4b1 electronic Treatment Administration Record (eTAR) and was signed by nurses as administered from Nj ex order 26.4b1

A review of the personalized care plan (CP) showed that the resident had focused on CP that was initiated on Nj ex order 26.4b for Nj ex order 26.4b1 " The goal was blank. The interventions listed were initiated also on Nj ex order 26.4 for "Nj ex order 26.4b1 "

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Further review of the CP revealed that the focus CP was incomplete, the goal was not set up, and the intervention did not include the specified rate and method of delivery. The CP also did not include NJ Ex Order 26.4b1 on how to store the [redacted] and supplies when not in use.

On 7/12/24 at 7:46 AM, the surveyor and the US FOIA (B) (6) went inside the resident's room, both observed the resident laying on the bed with Nj ex order 26.4b1 and the [redacted] The [redacted] checked the [redacted] with wrapped white tape and stated to the surveyor that the handwritten information on [redacted] at 6 AM was the date and time it was changed.

Afterward, both the surveyor and the [redacted] walked outside the resident's room and went to the nursing station. The surveyor asked the [redacted] about the above observation of the NC and [redacted] The surveyor also notified the [redacted] of the above observations of the [redacted] not properly stored NJ Exec Order 26.4b1 and the [redacted] was not in use when the nurses signed the eTAR that it was administered. The [redacted] stated that she would have to check and would get back to the surveyor.

On 7/12/24 at 7:49 AM, the surveyor interviewed the US FOIA (B) (6) the assigned nurse regarding the resident's [redacted] The [redacted] informed the surveyor that when she came in today at 7 AM, the resident's Nj ex order 26.4b1 and the resident Nj ex order 26.4b1. The [redacted] was unable to state if she observed at that time if the NJ ex order 26.4b1. She had no further

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F 695	Continued From page 65 comment when the surveyor asked the nurse why the resident had [NJ ex order 2] in use when the PO was [NJ ex order 26.4b1] On 7/12/24 at 10:27 AM, the survey team met with the [US FOIA (B) (6)] and [US FOIA (B) (6)] The surveyor notified the facility management of the above findings and concerns regarding the resident's PO for [NJ Exe] was not followed and improper storage of [NJ Exec] A review of the facility's Oxygen Administration Policy with a reviewed/revised date of 01/2024 that was provided by the [US FOIA (B)] revealed: Preparation: verify that there is a PO for this procedure. Review the PO or facility protocol for O2 administration. .. Steps in the procedure: .. #21. Replace the entire setup every seven days. Date and store in a treatment bag when not in use... On 7/15/24 at 11:53 AM, the survey team met with [US FOIA (B) (6)] and [US FOIA (B)] The [US FOIA (B)] stated that the physician was notified of the surveyor's concern and the facility received a new PO to change the order for [NJ Exec Order 26.4b1] to PRN (as needed) [NJ Exec] The [US FOIA (B)] further stated that the nurses should follow PO for [NJ Exe] and that [NJ Exec] should be properly stored inside a bag when not in use.	F 695		
F 711 SS=E	NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		7/29/24

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F 711	Continued From page 66 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that a.) the residents' US FOIA (b)(6) signed and dated monthly physician orders for residents under their care for one (1) of 38 residents (Resident #466) reviewed for physician order and b.) the residents US FOIA (b)(6) visited and documented monthly visits or alternately visited every other month when the US FOIA (b)(6) visited on the subsequent month for five (5) of 38 residents (Resident #18, #80, #227, #257, and #466), reviewed for physician visits. This deficient practice was evidenced by the following: 1. On 7/09/24 at 12:44 PM, the surveyor reviewed Resident #18's electronic medical record (EMR) which revealed that the resident's US FOIA (b)(6) did not document any visit for NJ ex order 26.4b1. The US FOIA (b)(6), covering for the US FOIA documented an NJ ex order and NJ ex order 26.4b1 monthly visit.	F 711	1. Physician visits were completed for Residents 18, 80, 227, 257, and 466. 2. All residents have the potential to be affected. 3. Education provided for US FOIA (b)(6) on signing and dating monthly physician orders for residents under their care, completing history and physicals, and the residents Attending Physician visits and documents monthly visits or alternately visited every other month when the Advanced Practice Nurse visited on the subsequent month. Unit clerks will track MD visits to ensure compliance. 4. DON/designee will audit 2 charts per week x 4 weeks, then monthly for 3 months, to ensure monthly visits have been completed as required and monthly physician orders signed. Results of the	

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F 711	Continued From page 67 There was not a documented US FO visit for Resident #18 for the last four months and there was no visit by the US FOIA (b) or US FO for NJ ex order 2 2. On 7/10/24 at 12:08 PM, the surveyor reviewed Resident #80's EMR which revealed that the resident's US FOIA (b)(6) did not document any visit for NJ ex order 26.4b1. The US FOIA (b) covering for the US FOIA documented only documented one visit which was dated NJ ex order 26.4b1 There was not a documented US FO visit for Resident #80 for the last four months and there was no visit by the US FOIA (b)(6) for NJ ex order 26.4b1 3. On 7/09/24 at 11:03 AM, the surveyor reviewed Resident #227's EMR which revealed that the resident's US FOIA (b)(6) did not document any visit for NJ ex order 26.4b1. The US FOIA (b) covering for the US FOIA documented only one visit which was dated NJ ex order 26.4b1. There was not a documented US FO visit for Resident #227 for the last three months and there was no visit by the US FOIA (b)(6) for NJ ex ord or NJ ex order 2 4. On 7/12/24 at 10:42 AM, the surveyor reviewed Resident #257's EMR which revealed that the resident's US FOIA (b)(6) did not document any visit for NJ ex ord or NJ ex order 26.4b1. The US FOIA (b) covering for the US FOIA documented the visits for NJ ex ord and NJ ex orde NJ ex order. There was not a documented US FO visit for Resident #257 for the last NJ ex order 26.4b1 On 7/11/24 at 12:08 PM, the surveyor interviewed the US FOIA (b)(6)) regarding the US FO visits. The US FOIA (b)(6) stated that the US FO visited the residents once a month and that the US FOIA (b) would come visit if the resident needed something sooner and that the visit was documented in the	F 711	audit will be reviewed by the administrator monthly at the QAPI meeting for 3 months.	

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electronic medical record.

On 7/12/24 at 10:32 AM, in the presence of the survey team, the surveyor notified the US FOIA (B) (6) and US FOIA (B) (6) the concerns that the residents did not have an US FO visit and that some months did not have an US FOIA (b)(6) monthly visit.

On 7/15/24 at 11:55 AM, in the presence of the survey team and US FOIA (B), the US FOIA (B) stated that the US FO provided notes. The surveyor asked the US FOIA (B) to confirm what date the US FO visited. The US FOIA (B) confirmed that the US FO visited on NJ ex order 26.4.

The facility did not provide any additional information.

5. On 7/08/24 at 11:34 AM, the surveyor observed Resident #466 lying on the bed.

The surveyor reviewed the EMR of Resident #466 and showed the following:

The Admission Record (an admission summary) reflected that the resident was admitted to the facility NJ ex order 26.4b1 and NJ ex order 26.4b1

The Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the

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management of care, with an assessment reference date (ARD) of [redacted] revealed in Section NJ Exec Order 26.4b1 a brief interview for mental status (BIMS) score of [redacted] out of 15 which reflected that the resident was NJ ex order 26.4b1.

A review of the monthly PO revealed the [redacted] and the [redacted] had not hand-signed or electronically signed monthly orders for NJ ex order 26.4b1 and [redacted].

Further review of the EMR revealed that the resident's [redacted] did not document any visits in [redacted] and [redacted]. The [redacted] did not document a NJ Exec Order 26.4b1 and the succeeding monthly visits for [redacted] and [redacted].

On 7/10/24 at 11:41 AM, the surveyor interviewed and asked the US FOIA (B) (6) where the [redacted] signed orders and how the nurse knew that the [redacted] signed the orders. The [redacted] stated that she was unsure how the [redacted] signs orders or if the [redacted] signs orders because she gets orders via phone call or enters the order of the [redacted] in the EMR. The [redacted] further stated that it would be the US FOIA (B) (6) [redacted] or the [redacted] who could answer the question on where the [redacted] signs orders.

On that same date and time, the surveyor asked the [redacted] where the [redacted] documents the [redacted] and succeeding progress notes (PN) of the [redacted]. The [redacted] then checked the EMR. The [redacted] acknowledged that she could not find the [redacted] and PN. The [redacted] stated that she would call the [redacted] and ask about it.

On 7/10/24 at 12:20 PM, the surveyor interviewed the [redacted]. The surveyor notified the [redacted] of the

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above findings and concerns. The [redacted] checked the resident's EMR and was unable to locate the [redacted] signed monthly orders, [redacted], and [redacted].

At that same time, the surveyor asked the [redacted] what the facility's policy and practices on how many days should the [redacted] and the [redacted] sign the orders and how many days should the physician visit and documents for succeeding [redacted] the [redacted] stated that she would get back to the surveyor.

On 7/12/24 at 10:27 AM, the survey team met with the [redacted] and [redacted]. The surveyor notified the facility management of the above findings.

A review of the facility's Policy and Procedure: Physician Responsibilities, Signatures, and Visits with a reviewed/revised date of 01/2024 that was provided by the LNHA revealed:
Purpose: to establish guidelines and standards for the responsibilities of physicians, including their signatures and visits, ensuring the highest quality of care for residents.
I. Responsibilities: ...iii. physicians must comply with all relevant federal, state, and local regulations and adhere to the standards set by accrediting bodies.
II. Documentation and signatures: a. all physician orders, progress notes, and other medical documentation must be dated, timed, and signed by the physician...c. physicians must ensure that all documentation is clear, accurate, and complete, and must be recorded in the resident's medical record in a timely manner. d. physicians must sign all medical orders, progress notes, care plans, and other relevant documentation in a timely manner. ...
IV. Visits: a. Initial visit, an initial visit comprehensive visit must be conducted by a

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F 711	Continued From page 71 physician within 48 hours of a resident's admission to the nursing home. This visit should include a complete physical examination, a review of medical history, and the development of an initial care plan. b. regular visits, a physician must visit residents regularly to monitor their health status, adjust care plans, and address any new medical issues. at a minimum, physicians should conduct visits every 30 days for the first 90 days after admission and then at least once every 60 days thereafter. On 7/15/24 at 11:53 AM, the survey team met with [redacted] and [redacted]. The [redacted] stated that the [redacted] entered a late entry for [redacted] and [redacted]. The [redacted] further stated that the physician orders were signed after the surveyor's inquiry.	F 711		
F 732 SS=D	NJAC 8.39-23.2(b)(d) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		7/29/24

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F 732	Continued From page 72 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to ensure the daily posting of licensed nurses, certified nursing aide staffing, and the resident census on three (3) of 10 days during the survey. This deficient practice was evidenced by the following: On Monday, 7/08/24 at 9:00 AM, upon entry into the facility, the surveyor observed a Nursing Home Resident Care Staffing Report (NHRCSR) which was posted in the reception area of the lobby. The NHRCSR posted for day shift was dated 7/07/24. There was no NHRSCR posted for 7/08/24 day shift.	F 732	1. The facility immediately posted the nurse staffing information at the time of the survey. No residents were affected by the deficient practice. 2. All residents have the potential to be affected. 3. Education provided for US FOIA (b)(6) [redacted] designee on Nursing Home Resident Care Staffing Report posting in front lobby. 4. Audits of Nursing Home Resident Care Staffing Report postings will be conducted by Administrator/ designee weekly for 4 weeks, then monthly for three	

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F 732	Continued From page 73 On Tuesday, 7/09/24 at 8:40 AM, the surveyor observed the NHRCSR posted in the lobby. The NHRCSR posted for day shift was dated 7/08/24. There was no NHRSCR posted for the 7/09/24 day shift. On Friday, 7/12/24 at 8:55 AM, the surveyor observed the NHRCSR that was posted in the reception area of the lobby. There was an NHRCSR dated 7/10/24 for the evening shift, 7/10/24 for the night shift, and 7/11/24 for the day shift. There was no NHRCSR posted for the 7/12/24 day shift. On 7/15/24 at 12:00 PM, in the presence of the survey team, the surveyor informed the US FOIA (B) (6) and the US FOIA (B) (6) US FOIA (B) (6) about the concern that the NHRSCR was not posted daily. On 7/15/24 at 01:30 PM, the US FOIA (B) informed the surveyor that the US FOIA (b)(6) was responsible for posting the NHRSCR and that he could provide further information to the surveyor. On 7/16/24 at 02:11 PM, the survey team met for Exit conference with US FOIA (B) (6) US FOIA (B) (6), and the US FOIA (B) (6) The facility management did not provide an additional information and did not refute the findings. NJAC 8:39-41.2	F 732	months. Results of the audit will be reviewed by the administrator monthly at the QAPI meeting for 3 months.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		7/29/24

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F 761	Continued From page 74 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to ensure that medications were stored securely and appropriately. This deficient practice was identified in one (1) of three (3) medication carts observed during the medication pass observation. This deficient practice was evidenced by the following: On 7/10/24 at 9:03 AM, the surveyor observed the US FOIA (b)(6) assigned to the NJ Exec Order 26.4b1 of the NJ Exec Order 4 (US FOIA (b)(6)) prepare and administer medications (meds) to an unsampled	F 761	1. The US FOIA (b)(6) was immediately educated by Director of Nursing on storage of medication. No residents were affected by the deficicent practice. 2. All residents have potential to be affected. 3. The Director of Nursing/ designee re-educated licensed staff on storage of medication.	

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F 761	Continued From page 75 resident. The surveyor observed the [redacted] US FOIA remove the resident's med cards (packaging that contains individual doses of med in a numbered plastic blister) and place them on top of the med cart. The surveyor observed the [redacted] US FOIA remove the ordered meds from the med cards for administration to the resident, verify the med, then return the med card to the cart after removing a dose. The surveyor observed the [redacted] US FOIA return the med cards that had doses removed to the med cart and then lock the cart. On that same date and time, the surveyor observed a single med card remaining on the top of the med cart. The surveyor asked the [redacted] US FOIA if the resident was getting this med as well. The med nurse stated, no, that this med was ordered for the evening, not at this time. The surveyor observed that med card did have the current resident's name and contained the med Xarelto (a medication used to reduce blood clotting). Afterward, the surveyor observed the [redacted] US FOIA enter the resident's room and administered meds to the resident, enter the resident's bathroom, perform handwashing, then return to the med cart. The surveyor asked the [redacted] US FOIA if the med card containing Xarelto should have been left on top of the med cart unattended. The [redacted] US FOIA stated, "no," it should have been locked inside the cart. On 7/10/24 at 9:25 AM, the surveyor interviewed the US FOIA (B) (6) for NJ Exec Order 26 The surveyor asked the US FOIA (B) (6) if it was appropriate to leave meds unattended on top of the med cart. The US FOIA (B) (6) stated that it was not appropriate and that meds should be locked up.	F 761	4. The Director of Nursing /designee will conduct observational audits x 4 to ensure no medications are stored on top of cart weekly x 4 weeks and then every 4 weeks x 2 months to ensure medication are stored properly. The findings of these audits will be reported to the monthly QAPI meeting.	

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F 761	Continued From page 76	F 761		

On 7/10/24 at 12:45 PM, the surveyor in the presence of the survey team requested facility policies for storage of meds, administration of meds and pharmacy consultant procedures from the facility administrator.

On 7/11/24 at 9:00 AM, the US FOIA (B) (6) US FOIA (B) (6) provided to the survey team, the facility policies that were requested the previous day as well as an incident report. The surveyor reviewed the facility policies and report and revealed the following:
The Storage of Meds policy which reflected a reviewed/revised date of NJ ex order 26.4b also reflected as a Policy Statement, "The facility shall store all drugs and biologicals in a safe, secure, and orderly manner."
The Administering Meds policy which reflected a reviewed/revised date of NJ ex order 26.4b also reflected on line 16 the statement "No meds are kept on top of the cart."

The surveyor reviewed the manufacturer's packaging information (PI) for Xarelto. The PI reflected under Adverse Reactions; the most common adverse reaction was bleeding. The PI also reflected under section 5.2 Risk of Bleeding, Xarelto increases the risk of bleeding and can cause serious or fatal bleeding.

On 7/12/24 at 10:27 AM, the surveyor in the presence of the survey team, met with the US FOIA (B) and US FOIA (B) (6) and discussed the med storage concern. The US FOIA (B) acknowledged the incident.

The facility did not provide any further pertinent information.

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F 761	Continued From page 77 NJAC 8:39-29.4(h)	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents it was determined that the facility failed to a.) to maintain proper kitchen sanitation practices in a manner to prevent food borne illness, and b.) discard potentially hazardous foods in a manner to prevent food borne illness. This deficient practice was evidenced by the following: On 7/08/24 at 9:34 AM, in the presence of the US FOIA (B) (6) the surveyor	F 812	1. The expired boxes of juice were disposed immediately, US FOIA (b)(6) verbally in serviced by Administrator. Long earrings were removed immediately and both employees were verbally in serviced by Food Service Director. Beard guard was immediately provided to employee and he was verbally in serviced by Food Service Director. 2. All residents have the potential to be affected.	7/29/24

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F 812	Continued From page 78 observed the following: 1. The juice dispenser machine which was attached to several large juice boxes to be dispensed included: -An "Unsweetened black" iced tea juice box had a manufacturing label with a "Best if Used by" date of 5/20/2024." -A "Cranberry Juice Fusion" juice box had a manufacturing label with a "Best if Used by" date of 11/28/2023." -A "thickened water nectar consistency" juice box with a manufacturing label with a "Best if Used by" date of 4/19/2024. The [US FOIA ID] acknowledged the boxes should have been disposed of and could not explain why they were still in use. The boxes were disposed. 2. Dietary Aide (DA) #1 wearing drop earrings hanging more than an inch from her ear. The surveyor interviewed DA#1 who stated she was not sure of the facility policy regarding earrings worn in the kitchen. The surveyor observed DA #2 wearing medium hoop earrings hanging down from her ears almost one inch. The surveyor interviewed DA#2 who stated she thought the earrings were okay as they were not large hoop earrings. The [US FOIA ID] was asked about earrings observed being worn in the kitchen by DA #1 and DA#2. The [US FOIA ID] stated servsafe guidelines indicated it shouldn't be worn. The [US FOIA ID] did provide further verbal response on the policy for jewelry in the kitchen. The surveyor requested the facility's policy on kitchen staff attire.	F 812	3. The Food Service Director/ designee re- educated dietary staff on the facility's food/ chemical storage and food preparation and service policy, and appropriate attire in the kitchen. 4. The Food service director/ designee will conduct a weekly audit x 4 weeks and then every 4 weeks x 2 to ensure compliance with food/ chemical storage and food preparation and service policy. The findings of these audits will be reported to the monthly QAPI meeting	

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F 812	Continued From page 79 On 7/09/24 at 10:45 AM, the survey toured the kitchen in the presence of the US FOIA (B) (6) The surveyor observed DA#3 who had hair on his chin which was exposed and not covered. The US FOIA (B) (6) stated DA #3 should have his facial hair covered with a beard restraint (cover) and instructed DA #3 to put on a beard cover. On 7/10/24 at 9:03 AM, the surveyor informed the US FOIA (B) (6) of the above concerns. There was no additional information provided by the facility. The surveyor reviewed the facility's policy titled, "Food/Chemical Storage" with a reviewed date of 5/01/24. The policy indicated that all foods should be covered, labeled, and dated and should be consumed within their use by dates. The surveyor reviewed the facility's policy titled "Food Preparation and Service" with a revised date of July 2024. Under the section Food Service/Distribution indicated "Dietary staff shall wear hair restraints (hair net, hat, beard restraint, etc.) so hair does not contact food." The policy also indicated " ...Jewelry shall be worn minimally ..." NJAC 8:39-17.2(g)	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		7/29/24

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F 880	Continued From page 80	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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F 880	Continued From page 81 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation, interview, and review of medical records and other pertinent facility documentation, it was determined that the facility failed to a.) follow appropriate hand hygiene practices during dining observation for one (1) of three (3) dining rooms, and for one (1) of two (2) staff (Housekeeper #1 [HK#1]) and b.) follow NJ Exec Order 26.4b1 to prevent the potential spread of NJ Exec Order 26.4 for two (2) of two (2) residents (Residents #41 and #111) and not utilizing personal protective equipment (PPE) for a resident on NJ Exec Order 26.4b1 for two (2) of two (2) staff (US FOIA (b)(6) and HK#2) reviewed for NJ Exec Or in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy.	F 880	1. No residents were affected by the deficient practice. The US FOIA (b)(6) was verbally in serviced on hand washing/ hand hygiene by Infection Preventionist. US FOIA (b)(6) # 1 were verbally in serviced on hand washing/ hand hygiene by Infection Preventionist. Personal Protective Equipment bin immediately provided outside Resident #111□s room and US FOIA (b)(6) verbally in serviced by Director of Nursing. US FOIA (b)(6) was verbally in serviced on NJ Exec Order 26.4 categories of NJ Exec Order 26.4b1 and hand hygiene by Infection Preventionist. The US FOIA (b)(6) was verbally in	

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F 880	Continued From page 82 This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers dated 02/27/24 revealed: Healthcare personnel should use an alcohol-based hand rub (ABHR) or wash with soap and water for the following clinical indications: Immediately before touching a patient Before and after eating Before performing an aseptic task or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient's immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal. 1. On 7/08/24 at 11:34 AM, the surveyor observed HK#1 wearing gloves while cleaning the toilet room of room [NJ ex orde]. After cleaning the toilet room, HK#1 went outside the room without removing used gloves and did not perform hand hygiene. HK#1 with used gloves pushed her cleaning cart in the middle of the hallway between rooms [NJ ex orde] and [NJ ex orde]. The surveyor then asked HK#1 if that was appropriate for her to have the gloves on while in the hallway. HK#1 immediately removed her used gloves and then pushed her cleaning cart in front of room [NJ ex orde] HK#1 went inside room [NJ ex orde]'s toilet room and immediately left the room, donned (applied) a new pair of gloves without performing hand hygiene. There was no resident inside room [NJ ex orde].	F 880	serviced by Director of Nursing about offering a bedside commode to a non-infected resident sharing a room with a resident on transmission-based precautions. 2. All residents have the potential to be affected. 3. The Infection Preventionist/ designee educated facility staff on the facilities Isolation Policy and isolation categories of transmission-based precautions Policy and hand hygiene. 4. The Infection Preventionist/ designee will conduct a weekly focused infection control audits x 4 weeks and then every 4 weeks x 2 months to ensure appropriate signage, availability of personal protective equipment, adherence to guidelines regarding personal protective equipment use by staff. The infection preventionist / designed will conduct 2 hand hygiene competencies per week x 4 weeks, then every 4 weeks x 2 months. The findings of these audits will be reported to the monthly QAPI meeting	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 83 On 7/08/24 at 11:48 AM, the surveyor notified Registered Nurse #1 (RN#1) of the above concern regarding HK#1. The [US FOIA] stated that she would notify the US FOIA (b)(6) about it. The [US FOIA] further stated that HK#1 should have removed gloves and performed hand hygiene prior to leaving the room and not wear gloves in the hallway. A review of the provided Handwashing/Hand Hygiene Policy that was provided by the US FOIA (b)(6) with a reviewed/revised date of 01/2024 showed: Policy Interpretation and Implementation:.. #7 Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: -before donning gloving gloves; -after contact with objects in the immediate vicinity of the resident; -after removing gloves; #8 Hand hygiene is the final step after removing and disposing of PPE. #9 The use of gloves does not replace hand washing/hand hygiene. 2. On 7/08/24 at 11:40 AM, the surveyor observed a lunch food truck parked in front of the nursing station of the [NJ Exc] unit. The US FOIA (b)(6)) took the lunch food truck into the dining room wherein there were five residents inside the room. There was a container of hand wipes inside the dining room. The residents were not offered or provided hand hygiene. Certified Nursing Aide #1 (CNA#1) distributed lunch trays to four residents. On 7/10/24 at 8:57 AM, the surveyor interviewed CNA#1 in front of the [NJ Exc] nursing station. The	F 880		

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surveyor notified the [redacted] of the above concerns regarding no hand hygiene provided to the residents in the dining area on 7/08/24 during lunch observation. The [redacted] stated that one of the residents in the dining room on 7/08/24 was assigned to her and she did the hand hygiene of the resident in the morning prior to going to the dining room and not before lunch. CNA#1 acknowledged that she was unsure if hand hygiene was provided to five residents in the dining room on [redacted] before and after lunch.

On 7/10/24 at 9:06 AM, the surveyor interviewed RN#1. The [redacted] acknowledged that she did not observe that the facility staff during lunch at the dining room provided hand hygiene to the residents prior to lunch. She further stated that she would reinforce it to the staff.

On 7/12/24 at 10:27 AM, the survey team met with the [redacted] and [redacted]
The surveyor notified the facility management of the above findings and concerns regarding HK#1 and dining observation.

On 7/12/24 at 12:41 PM, the surveyor interviewed the [redacted] The surveyor notified the above concerns regarding HK#1 and dining observation. The [redacted] stated that the residents in the dining area should have been offered hand hygiene by staff. She further stated that HK#1 should remove used gloves before exiting the resident's room and staff should not wear PPE including gloves in the hallway for infection control.

A review of the facility's Handwashing/Hand Hygiene Policy with a reviewed/revised date of 01/2024 that was provided by the [redacted] revealed:

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F 880	Continued From page 85 Policy Interpretation and Implementation:... #7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: ... o. before and after eating or handling food; p. before and after assisting a resident with meals... On 7/15/24 at 11:53 AM, the survey team met with [redacted] and [redacted]. The [redacted] stated that "we" in-service the staff in the [redacted] unit and HK#1 about hand hygiene. 3. During initial tour on 7/08/2024 at 10:10 AM, the surveyor observed an [redacted]) in nursing homes) signage above the name plate of Resident #111's room. The surveyor did not observe any additional signage and there was no PPE bin observed at the doorway. On 7/09/2024 at 11:56 AM, the surveyor observed a [redacted] sign above the name plate of Resident #111's room. There was also PPE bin by the door which had blue disposable gowns and face shields. The surveyor observed that the [redacted] sign at the door indicated "Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Put on gown before room entry." The surveyor reviewed the medical records for Resident #111 which revealed the following:	F 880		

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F 880	Continued From page 86 According to the Admission Record (AR; an admission summary), Resident #111 was admitted to the facility NJ ex order 26.4b1, NJ ex order 26.4b1 and NJ ex order 26.4b1 and NJ ex order 26.4b1 The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b, reflected a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15, which indicated that the resident NJ ex order 26.4b1 A review of Order Summary Report (OSR), included a physician order (PO), dated NJ ex order 26.4b1 at 15:00 (3:00 PM) which read, "NJ ex order 26.4b1 23:59 (11:59 PM)." A review of a nursing progress note (PN) dated NJ ex order 26.4b1 at 8:51 AM indicated Resident #111 had a NJ ex order 26.4b1 for NJ ex order 26.4b1 On 7/12/24 at 11:19 AM, the surveyor conducted an interview with the US FOIA (B) (6) US FOIA (B) (6) who stated she would contact the physician and US FOIA (B) immediately once a resident had a new NJ Exec Order 2	F 880		

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NJ Exec Order 26.4b1. The US FOIA (B) (6) further stated a resident would be placed on NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 and a PPE bin would be placed at the door of the room. The US FOIA (B) (6) further stated that it was important to place a NJ Exec Order 26.4b1 signage to prevent the spread of NJ Exec Order 26.4b1.

On 7/15/24 at 11:01 AM, the surveyor conducted an interview with the US FOIA (B) who explained that as soon as nursing staff found out that a resident had an NJ Exec Order 26.4b1 they would notify the US FOIA (B) and if it was an NJ Exec Order 26.4b1 that required NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 it would be implemented by nursing staff. The US FOIA (B) (6) stated that the PO for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and a care plan would be entered in the EMR (Electronic Medical Record). A PPE bin and a NJ Exec Order 26.4b1 sign would be posted above the name plate at the resident's door. The US FOIA (B) further explained that "We do not need PO and nurses can initiate NJ Exec Order 26.4b1." She stated that it was important to place NJ Exec Order 26.4b1 signage and PPE bin at the door to prevent the spread of NJ ex order 26.4b1.

On 7/15/24 at 12:00 PM, the survey team met with US FOIA (B) and US FOIA (B) The surveyor notified the facility management of the above findings.

On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6), and US FOIA (B) (6) for an Exit Conference. The facility did not provide any additional information.

4. On 7/09/2024 at 11:56 AM, the surveyor observed a NJ Exec Order 26.4b1 sign above the name plate of Resident #111 and Resident #91's

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room. On the sign, there was a small round sticker at the middle-bottom with #1 written in black, which indicated that resident in bed 1 (Resident #111) NJ ex order 26.4b1 .

The surveyor reviewed the medical records for Resident #91 which revealed the following:

The AR documented Resident #91 was admitted to the facility NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 and NJ ex order 26.4b1 [redacted].

A comprehensive MDS (CMDS) dated NJ ex order 26.4b, reflected a BIMS score of [redacted] out of 15, which indicated that Resident #91 had NJ ex order 26.4b1 [redacted]. Further review of the MDS in Section [redacted] for NJ Exec Order 26.4b1, indicated that Resident #91 NJ ex order 26.4b1 [redacted] Section H for NJ Exec Order 26 and NJ Exec Order indicated that Resident #91 NJ ex order 26.4b1 [redacted]

A review of OSR and nurse progress notes revealed Resident #91 NJ ex order 26.4b1 [redacted]

On 7/12/24 at 11:19 AM, the surveyor conducted an interview with the US FOIA (B) (6) who stated that she would immediately remove a resident out of the room if she found out one (1) of the two (2) residents needed to be placed on NJ ex order 26.4 [redacted]. The US FOIA (b)(6) confirmed Resident #111 NJ ex order 26.4b1 and their roommate, Resident #91 NJ ex order 26.4b1.

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F 880	Continued From page 89 On 7/15/24 at 10:34 AM, the surveyor conducted an interview with CNA#2 who was assigned to care for Resident #91 and Resident #111. The [US FOIA (b)] stated Resident #111 [NJ ex order 26.4b1] and [NJ ex order 26.4b1] of the resident's room. The [US FOIA (b)] stated that Resident #91 [NJ ex order 26.4b1] and [NJ ex order 26.4b1] On 7/15/24 at 11:01 AM, the surveyor conducted an interview with the [US FOIA (b)] who stated that she had discussed with the [US FOIA (b)(6)] regarding Resident #91 who [NJ ex order 26.4b1] and Resident #111 [NJ ex order 26.4b1]. The [US FOIA (b)(6)] continued that the [US FOIA (b)(6)] said it was okay for the residents to share a room as Resident #111 [NJ ex order] [NJ ex order 26.4b1]. The [US FOIA (b)(6)] stated that when the staff dumped the [NJ Exec Ord] in the [NJ Exec Ord] if anything splashed, they were to make sure the toilet was wiped off with "sani-wipes" [a disposable wipe that destroys harmful microorganisms] as standard precautions. On 7/15/24 at 12:00 PM, the survey team met with the [US FOIA (B) (6)] and [US FOIA (B)]. The surveyor informed the facility management of the above findings. There was no verbal response by the facility at this time. On 7/15/24 at 01:40 PM, the surveyor conducted an interview with CNA#2 who stated that after disposing the [NJ Exec Ord] in the [NJ Exec Ord] she flushed the [NJ Exec Ord] and did not wipe the [NJ Exec Ord]. The [US FOIA (B)] further	F 880		

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stated that "we don't clean the bathroom. That's not part of our job."

On 7/16/24 at 02:11 PM, the survey team met the US FOIA (B) (6), and US FOIA for an Exit Conference. The facility did not provide any additional information.

5. On 7/12/24 at 11:13 AM, the surveyor observed the NJ Exec Order 26.4b1 Signage above the name plate of Resident's room and PPE bin was at the doorway. The surveyor observed a HK#2 wearing gloves and entered Resident #111's room. The housekeeper was observed in the resident's room without wearing a PPE gown, which was indicated on the signage to be worn while inside the room.

The surveyor conducted an interview with HK#2 after she exited Resident #111's room. HK#2 stated the NJ Exec Order 26.4b1 sign above the name plate was an NJ Exec Order 26.4b1 and that a "NJ Exec Ord is not compulsory for housekeeping staff when entering into this room."

The surveyor reviewed the medical records for Resident #111 and revealed in the OSR, included a PO, dated NJ ex order 26.4b1 at 15:00 (3:00 PM) which read, NJ ex order 26.4b1 23:59 (11:59 PM)."

On 7/12/24 at 11:19 AM, the surveyor conducted an interview with the US FOIA (B) (6) who acknowledged that Resident #111 NJ ex order 26.4b1 Resident #111's room.

On 7/12/24 at 12:42 PM, the surveyor conducted an interview with the US FOIA (B) who stated that any

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F 880	Continued From page 91 staff entering a [redacted] room was required to don gown and gloves. The [redacted] acknowledged that the HK#2 should have donned a gown and gloves before entering the resident's room. On 7/15/24 at 12:00 PM, the survey team met with [redacted] and [redacted] The surveyor notified the facility management of the above findings. A review of the facility provided "Isolation-categories of TBP" policy revised on 12/2023 included: Policy Statement 1. Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. TBP shall be used when caring for residents who are documented or suspected to have communicable disease or infections that can be transmitted to others. Policy Interpretation and Implementation: 1. TBP will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection. Contact Precautions 1. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on a case by case basis. 5. Gown: a.) Wear a disposable gown upon entering the Contact Precautions room or cubicle. 8. Signs- The facility will implement a system to	F 880		

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F 880	Continued From page 92 alert staff to the type of precaution resident requires a.) This facility utilizes the following system for identification of Contact Precautions for staff and visitors: _____STOP SIGN-- SEE NURSE BEFORE ENTERING ROOM___. On 7/16/24 at 02:11 PM, the survey team met the [redacted], and [redacted] for an Exit Conference. The facility did not provide any additional information. 6. On 7/12/24 at 12:18 PM the surveyor observed the [redacted] signage above the room number name plate outside Resident #41's room and a bin of PPE. The bin contained disposable gowns, disposable gloves, masks, and face shields. The [redacted] reflected that prior to entering the room to clean the hands, put on a disposable gown, put on disposable gloves and to clean hands with soap and water on exit. The surveyor also observed at the same time, a male individual with a stethoscope exit Resident #41's room and proceed directly to another resident room. The surveyor asked the [redacted] who was present in the hallway to identify the individual. The [redacted] stated that he was the [redacted] for Resident #41 and Resident #103 which resided in the same room. The surveyor did not observe the [redacted] remove and dispose of any PPE including a gown, gloves, or mask before exiting Resident #41's room and the surveyor did not observe the [redacted] perform any	F 880		

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F 880	Continued From page 93 hand hygiene including hand washing prior to exiting the resident's room. The surveyor asked the [redacted] if the [redacted] should follow the procedure for NJ Exec Order 26.4b1. The [redacted] stated "yes, he should have." The surveyor observed the [redacted] approach the [redacted] and inform him of the observation and of the NJ Exec Order 26.4b1 signage. The surveyor asked the [redacted] the procedure for visitors who would want to enter a room with NJ Exec Order 26.4b1 [redacted]. The [redacted] stated that a visitor would be advised to use PPE and hand hygiene, as well as disposal of PPE in receptacle at the doorway. If the visitor refused, they would be advised of the risks. On 7/12/24 at 12:55 PM, the surveyor interviewed the [redacted]. The surveyor asked what the expectation was for all staff and providers when entering and leaving a room that was identified as NJ Exec Order 26.4b1. The [redacted] stated that the expectation for staff and physicians to use PPE, wear and remove it appropriately and use hand hygiene upon entry and exit for any Isolation room including NJ Exec Order 26.4b1. On 7/15/24 at 10:00 AM, the surveyor interviewed the [redacted]. The surveyor asked the [redacted] if physicians were expected to follow the same infection control practices and policies as the other staff. The [redacted] stated, "yes," they should and that they should be educated and informed of those policies and procedures for [redacted]. The facility provided no further information pertinent to this observation.	F 880		

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F 880	Continued From page 94 7. On 7/12/24 at 12:18 PM the surveyor observed the NJ ex order 26.4b1 posted outside the room for Resident #41 and Resident #103. The surveyor reviewed the medical record for Resident #41 which revealed the following: According to the AR, the resident was admitted to the facility with diagnoses NJ ex order 26.4b1 The CMDS dated 6/20/24, reflected a BIMS score of NJ ex out of 15 which indicated the resident was NJ ex order 26.4b1. Section H of the MDS, NJ ex order 26. reflected that Resident #41 had NJ ex orde The resident's OSR for "other orders" indicated a PO dated NJ ex order 26.4b with an end date of NJ ex order 26.4b for "NJ Exec Order 26.4b1 " The resident's recent laboratory results revealed NJ ex order 26.4b1 The US FOIA (b)(6) Progress notes revealed a US FOIA (b)(6) encounter note dated NJ ex order 26.4b by the resident's US FOIA The note included NJ ex order 26.4b1 . Further review of Resident #41's medical record	F 880		

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revealed the [NJ Exec Order 26.] policy was in effect for Resident #41 during the [NJ ex order 26.4b1] of an [NJ Exec Order 26.] that could be transmitted.

The surveyor reviewed the medical record for Resident #41 which revealed the following:
A review of Resident #103's Quarterly MDS dated [NJ ex order 26.] revealed that Section [NJ] reflects the NJ ex order 26.4b1 .

Further review of Resident #103's medical record revealed the resident NJ ex order 26.4b1

On 7/15/24 at 10:07 AM, the surveyor interviewed CNA#3 that provides care for both Resident #41 and Resident #103. The [US FOIA (B)] stated that Resident #41 NJ ex order 26.4b1 . The [US FOIA (B)] stated that Resident #103 also NJ ex order 26.4b1 when they can not get to the [NJ Exec Order 26.4b] in time. The surveyor asked the [US FOIA (B)] if Resident #103 uses the [NJ Exec O] located in the room. The [US FOIA (B)] responded, [NJ ex orde] The surveyor asked the [US FOIA (B)] if both NJ ex order 26.4b1 in the resident's room. The [US FOIA (B)] stated, "yes."

On 7/15/24 at 10:43 AM, the surveyor interviewed the [US FOIA (B) (6)] in the presence of the survey team. The [US FOIA (B)] was asked why a resident who NJ ex order 26.4b1 in the same room as a resident who did not. The [US FOIA (B)] stated that as of [NJ ex order 26.4], Resident #41 was considered [NJ ex] NJ ex order 26.4b1 and a NJ ex order 26.4b1 . Resident #41's roommate, Resident #103 [NJ ex order 26.4b1] and

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	315303	A. BUILDING _____ B. WING _____	C 07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 96 Resident #103 NJ ex order 26.4b1 The US FOIA (b)(6) stated she was not aware that Resident #103 used the NJ Exec O and that she thought the resident NJ ex order 26.4b1 The US FOIA (B) NJ ex order 26.4b1 She further acknowledged that if she knew that Resident #103 NJ ex order 26.4b1 A review of the facility's Isolation Policy dated 12/2023 that was provided by the LNHA showed the following: Under the section Contact Precautions, Number 2, line b., Diarrhea associated with Clostridium Difficile. Number 3 Resident Placement, a. Place the resident in a private room if possible. b. If a private room is not available, the Infection Preventionist will assess the various risks associated with resident placement options (e.g., cohorting, placing with a low risk roommate). Number 4 Gloves and Handwashing, line a., In addition to wearing gloves as outlined under Standard Precautions, wear gloves...when entering the room. line c., Remove gloves before leaving the room and perform hand hygiene. Number 5 Gown, line a., Wear a disposable gown upon entering a Contact Precautions room or cubicle.	F 880		
F 921 SS=E	NJAC 8:39-19.4(a)(1)(2)(c)(m)(n), 27.1(a) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		7/29/24

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F 921	Continued From page 97 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for a.) one (1) of three (3) residents' rooms (Resident #32) and b.) two (2) of two (2) common rooms (toilet and chapel room) This deficient practice was evidenced by the following: 1. On 7/15/24 at 10:09 AM, the surveyor met and interviewed Resident#83. The resident requested the follow-up personal meeting after the resident council meeting with another surveyor on [NJ Exec Order 26 redacted]. The resident discussed the [NJ Exec Orde redacted] public toilet room safety railing was loose which Resident #83 had previously reported to the US FOIA (B) (6) [redacted] and the US FOIA (B) (6) [redacted] via email. The resident further stated that the [NJ Exec Ord redacted] public toilet room was being used by residents. On that same date and time, the resident also mentioned the chapel where residents gather for religious services had an incident/accident a month ago with one resident (Resident #35) [NJ ex orde redacted]. The resident stated that he/she reported the NJ ex order 26.4b1 to the US FOIA (b)(6) [redacted]) who told the resident that "they" were not responsible for [NJ ex order 26.4b1 redacted]. Resident #83 further stated that since then [NJ ex o redacted]. On 7/15/24 at 10:44 AM, the surveyor with the [US FOIA (B) redacted] went to the chapel and NJ ex order 26.4b1	F 921	1. 1A/B public toilet room safety railing was repaired Carpet in chapel immediately cleansed by housekeeping staff Ceiling tiles replaced 7/29/24 . In Resident #32s room, the floor was stripped and waxed by housekeeping staff, paint touched up by maintenance staff, and toilet railing repaired. 2. All residents have the potential to be affected. 3. The Housekeeping Director/ designee educated housekeeping and maintenance staff on the facility's Safe and Homelike Environment Policy. 4. The Housekeeping Director/ designee will conduct a weekly audit of one housekeeping staff assignment x 4 weeks and then every 4 weeks x 2 to ensure compliance with Safe and Homelike Environment Policy. The findings of these audits will be reported to the monthly QAPI meeting	

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F 921	Continued From page 98	F 921		

NJ ex order 26.4b1 #1, 2, and 3 on the chapel carpet floor. The surveyor notified the US FOIA (B) of the concern of Resident #83 about an incident a month ago NJ ex order 26.4b1 and the US FOIA (B) stated that he would get back to the surveyor. The US FOIA (B) further stated that it should have been cleaned.

On 7/15/24 at 10:55 AM, the surveyor interviewed the Infection US FOIA (B) (6) The US FOIA (B) stated that when there was a NJ Exec Order 26.4b1 on the floor, the facility uses the NJ Exec Ord spill kit by nursing and then housekeeping will clean afterward.

At that time, the surveyor with the US FOIA (B) (6) went inside the chapel and showed the NJ Exec Order 26.4b1 on the carpet. Both the surveyor and the US FOIA (B) observed the two housekeeping personnel cleaning the area where there was a NJ Exec Order 26.4b1. Both the housekeeping personnel informed the surveyor and the US FOIA (B) that they did not know that there was a stain on the carpet because no one told them about it and now it was hard to remove.

Furthermore, the surveyor and the US FOIA (B) (6) also observed the six ceiling tiles with brownish discoloration which the US FOIA (B) claimed was probably due to condensation.

On 7/15/24 at 11:53 AM, the survey team met with US FOIA (B) and the US FOIA (B) (6) The surveyor notified the facility management of the above findings and concerns.

On that same date and time, the US FOIA (B) provided a piece of paper with Resident #35's name on it and the date of the NJ ex order 26.4b1 that

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happened on NJ Exec Order 26.4b1.

On 7/16/24 at 10:23 AM, the surveyor and the US FOIA (B) both went to the NJ Exec Ord public toilet room and both observed the safety railings were loose when the US FOIA (B) attempted to shake it. The US FOIA (B) stated that he would call US FOIA (b)(6) immediately to fix it.

On 7/16/24 at 12:32 PM, the survey team met with the US FOIA (B) (6), and US FOIA (B) (6) . The US FOIA (B) stated that the facility ordered new ceiling tiles for the chapel.

2. On 7/10/24 at 11:33 AM, the unsampled Resident #32 was seen in their room at their request. The resident was sitting in their NJ ex order 26.4b1 and pointed towards their room floor and walls to show the chipped and faded paint with black colored streaks on the left wall (Bathroom back wall) and back wall left of the headboard. The surveyor observed the floor tiles with brown and black scattered discoloration large markings. The surveyor observed few patches where the paint had come off from the front wall next to the television (TV).

The surveyor reviewed the medical records for Resident #32 which revealed the following:

According to the Admission Record (an admission summary), Resident #32 was admitted to the facility NJ ex order 26.4b1

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F 921	Continued From page 100 The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], Section [redacted] revealed that Resident #32 [redacted] At 11:50 AM, the surveyor conducted an interview with [redacted], who looked at the floor and identified that "it's (the floor) got to be clean." [redacted] further stated if the floor needs to be stripped, they contact the [redacted] acknowledged that "It's (the floor) got to be stripped and waxed." The [redacted] further stated that [redacted] does the painting, repairs, plumbing, fix TV and sinks. At 12:11 PM, the surveyor conducted an interview with [redacted] in unsampled Resident #32's room and [redacted] acknowledged that it was not acceptable the way the room paint looked in that room. The surveyor observed two ceiling tiles with brownish-dried discoloration marks close to the window. [redacted] identified there was a leak more than a year ago. [redacted] stated, "he fixes worse things first." At that same time, the surveyor and [redacted] toured the resident's bathroom. [redacted] was able to lift up the right front leg of the toilet railing. [redacted] stated, "we don't secure it because the toilet is fixed to the wall and incase if the toilet needs to be replaced." On 7/12/24 at 11:01 AM, the surveyor observed the unsampled Resident #32's toilet railing and it was loose. On 7/15/24 at 10:25 AM, two surveyors visited the	F 921		

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F 921	Continued From page 101 unsampled Resident #32's toilet railing and it was loose. On 7/15/24 at 12:00 PM, the survey team met with US FOIA (B) and US FOIA (B). The surveyor notified the facility management of the above findings. A review of the facility's undated Safe and Homelike Environment Policy provided by the LNHA revealed:... In accordance with resident's rights, the facility will provide a safe, clean comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Policy Explanation:... #3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment..... #9. General Considerations:... c. Report any furniture in disrepair to Maintenance promptly. d. Report any unresolved environmental concerns to the Administrator..... On 7/16/24 at 02:11 PM, the survey team met for an Exit conference with US FOIA (B) (6), US FOIA (B) (6), and the US FOIA (b)(6). The facility management did not provide additional information and did not refute the findings. NJAC 8:39-31.4 (a)(b)(f)	F 921		

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	061411	A. BUILDING: _____ B. WING _____	C 07/24/2024

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Complaint # NJ172084 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 14 of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	1. No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted. 2. All residents could be affected by not meeting State of NJ minimum staffing requirements. 3. The Administrator educated the Director of Nursing and Staffing Coordinator on State of New Jersey minimum staffing requirements. The facility has contracted with one outside recruitment agency to support recruitment and retention efforts for the facility. In addition, the facility	7/29/24

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

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 03/03/2024 to 03/16/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -03/03/24 had 15 CNAs for 264 residents on the day shift, required at least 33 CNAs. -03/04/24 had 25 CNAs for 264 residents on the day shift, required at least 33 CNAs. -03/05/24 had 32 CNAs for 264 residents on the day shift, required at least 33 CNAs. -03/06/24 had 25 CNAs for 264 residents on the day shift, required at least 33 CNAs. -03/07/24 had 31 CNAs for 268 residents on the day shift, required at least 33 CNAs. -03/08/24 had 27 CNAs for 268 residents on the day shift, required at least 33 CNAs. -03/09/24 had 22 CNAs for 268 residents on the	S 560	continueds to implement other recruitment and retention efforts including: a. Job fairs b. Bi weekly staffing meetings and weekly Regional Labor Management reviews c. Training mentor program to support retention d. Culture committee to improve and maintain staff morale e. Recruitment bonus and sign-on bonuses offered. f. Competitive wage analysis g. Shift pick up bonuses h. 2 nurse staffing agencies 4. To monitor and maintain ongoing compliance the Director of Nursing or designee will conduct audits of 3 shifts nursing staff 2 x weekly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement team monthly for continued review and recommendations until substantial compliance is maintained.	

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S 560	Continued From page 2 day shift, required at least 33 CNAs. -03/10/24 had 16 CNAs for 266 residents on the day shift, required at least 33 CNAs. -03/11/24 had 28 CNAs for 265 residents on the day shift, required at least 33 CNAs. -03/13/24 had 20 CNAs for 262 residents on the day shift, required at least 33 CNAs. -03/14/24 had 32 CNAs for 262 residents on the day shift, required at least 33 CNAs. -03/15/24 had 27 CNAs for 262 residents on the day shift, required at least 33 CNAs. -03/16/24 had 23 CNAs for 266 residents on the day shift, required at least 33 CNAs. 2. For the 2 weeks of staffing prior to survey from 06/23/2024 to 07/06/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -06/23/24 had 20 CNAs for 253 residents on the day shift, required at least 32 CNAs. -06/24/24 had 22 CNAs for 253 residents on the day shift, required at least 32 CNAs. -06/25/24 had 30 CNAs for 253 residents on the day shift, required at least 32 CNAs. -06/26/24 had 27 CNAs for 253 residents on the day shift, required at least 32 CNAs. -06/27/24 had 27 CNAs for 256 residents on the day shift, required at least 32 CNAs. -06/28/24 had 28 CNAs for 256 residents on the day shift, required at least 32 CNAs. -06/29/24 had 25 CNAs for 256 residents on the day shift, required at least 32 CNAs. -06/30/24 had 20 CNAs for 256 residents on the day shift, required at least 32 CNAs. -07/01/24 had 22 CNAs for 259 residents on the day shift, required at least 32 CNAs. -07/02/24 had 29 CNAs for 257 residents on the day shift, required at least 32 CNAs. -07/03/24 had 28 CNAs for 257 residents on the day shift, required at least 32 CNAs.	S 560		

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-07/04/24 had 26 CNAs for 257 residents on the day shift, required at least 32 CNAs.
-07/05/24 had 30 CNAs for 257 residents on the day shift, required at least 32 CNAs.
-07/06/24 had 21 CNAs for 258 residents on the day shift, required at least 32 CNAs.

On 7/16/24 at 8:47 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA). The LNHA stated that he was aware of the Facility Assessment staffing plan. He further stated that he was aware that not all the time the facility was meeting the staffing plan and, "yes I'm aware of the short staffing." He also indicated that he was aware of the NJ mandated staffing law and that they (facility) tried to meet the requirements.

During an interview with the surveyor on 7/16/24 at 9:08 AM, the Staffing Coordinator (SC) stated that she was unaware of the State's minimum staffing ratios for 7 AM - 3 PM day shift, 3 PM -11 PM evening shift, and 11 PM -7 AM night shift.

A review of the Facility Assessment with a review date of 3/01/24 that was provided by the LNHA revealed that the Staffing Plan included the following:
Day (7-3 shift): Registered Nurse (RN) total of 4, Licensed Practical Nurse (LPN) total of 8, CNA total of 33
Evening (3-11 shift): RN 5, LPN 7, CNA 27
Night (11-7 shift): RN 2, LPN 4, CNA 19
Nursing Management: DON, ADON, 1 MDS Coordinator, Unit Managers and/or shift supervisors to oversee the care and services provided by nursing staff.

On 7/16/24 at 02:11 PM, the survey team met the LNHA, Director Of Nursing, Chief Nursing Officer,

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S 560	Continued From page 4 Corporate Compliance Officer, and Regional Administrator for an Exit Conference. The facility did not provide additional information and did not refute the findings.	S 560		

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{E 000}	Initial Comments An onsite revisit was conducted regarding the 7/24/2024 Recertification survey. The facility was found to be in substantial compliance with the implementation of their POC.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite revist was conducted for the 7/24/2024 Recertification survey. The facility was found to be in substanial compliance with the implementation of their POC.	{F 000}		

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

Electronically Signed | 09/04/2024

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315303	A. Building B. Wing	8/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0009 Reg. # 483.73(a)(4) LSC	Correction Completed 07/29/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315303	A. Building B. Wing	8/30/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 07/29/2024	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 07/29/2024	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 08/09/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315303 Y1	A. Building B. Wing Y2	8/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0550	Correction	ID Prefix F0607	Correction	ID Prefix F0636	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(1)-(5)(ii)(iii)	Completed	Reg. # 483.20(b)(1)(2)(i)(iii)	Completed
LSC	07/29/2024	LSC	07/29/2024	LSC	07/29/2024
ID Prefix F0638	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.20(c)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	07/29/2024	LSC	07/29/2024	LSC	07/29/2024
ID Prefix F0661	Correction	ID Prefix F0684	Correction	ID Prefix F0689	Correction
Reg. # 483.21(c)(2)(i)-(iv)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	07/29/2024	LSC	07/29/2024	LSC	08/09/2024
ID Prefix F0695	Correction	ID Prefix F0711	Correction	ID Prefix F0732	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.30(b)(1)-(3)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	07/29/2024	LSC	07/29/2024	LSC	07/29/2024
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	07/29/2024	LSC	07/29/2024	LSC	07/29/2024

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315303 Y1	A. Building B. Wing Y2	8/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0921 Reg. # 483.90(i) LSC	Correction Completed 07/29/2024				

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/24/2024	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061411	A. BUILDING: _____ B. WING _____	R-C 08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	Initial Comments An onsite revisit was conducted regarding the 7/24/2024 Recertification survey. The facility was found not to be in compliance with the implementation of their POC.	{S 000}		
{S 560}	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was an uncorrected deficiency, cited during the standard survey of 7/24/24. A POC (plan of correction) submitted by the facility failed to correct the deficient practice. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	{S 560}	1. No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted. 2. All residents could be affected by not meeting State of NJ minimum staffing requirements. 3. a. The Administrator educated the Director of Nursing and Staffing Coordinator on State of New Jersey minimum staffing requirements. b. The facility contracted with an additional nurse staff agency to meet the State of New Jersey minimum staffing requirements. c. Daily C.N.A staffing ratio review. d. Assistant Administrator: In house Talent acquisition Specialist. c. Facility Ancillary Staff: Offer C.N.A. traing course. d. Local C.N.A./ L.P.N. school	9/7/24

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

Electronically Signed | 09/04/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061411	A. BUILDING: _____ B. WING _____	R-C 08/30/2024

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{S 560}	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing prior to survey from 08/11/2024 to 08/24/2024, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows: -08/11/24 had 16 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/12/24 had 24 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/13/24 had 28 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/14/24 had 24 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/15/24 had 26 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/16/24 had 24 CNAs for 262 residents on the day shift, required at least 33 CNAs. -08/17/24 had 28 CNAs for 262 residents on the day shift, required at least 33 CNAs. -08/18/24 had 25 CNAs for 262 residents on the day shift, required at least 33 CNAs. -08/19/24 had 29 CNAs for 262 residents on the day shift, required at least 33 CNAs.	{S 560}	partnerships. e. Weekly staff appreciation events. 4. To monitor and maintain ongoing compliance the Director of Nursing or designee will conduct audits of 3 shifts nursing staff 3 x weekly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement team monthly for continued review and recommendations until substantial compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061411	A. BUILDING: _____ B. WING _____	R-C 08/30/2024

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{S 560}	Continued From page 2 -08/22/24 had 31 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/23/24 had 32 CNAs for 261 residents on the day shift, required at least 33 CNAs. -08/24/24 had 29 CNAs for 263 residents on the day shift, required at least 33 CNAs. On 8/30/24 at 11:46 AM, the surveyor interviewed the Staffing Coordinator (SC) in the presence of another surveyor. The SC stated that the facility was able to meet the requirement of required CNA for August 2024. The SC further stated that for yesterday's staffing, the requirement was 33 CNAs and that the 33 CNAs was based on census. The SC was not sure if the requirement for 33 CNA was meant to comply with the NJ mandated law for staffing. On 8/30/24 at 01:05 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing for a brief exit conference. The surveyor notified the facility management of the staffing concern. The LNHA stated that there were some days that the facility did not meet the requirement for staffing, and he was aware of it. He further stated that the facility was trying their best to meet the mandated staffing requirement. No further information was provided.	{S 560}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061411	A. Building B. Wing	9/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/07/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE** **MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 10/25/2023, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The building is a four-story building that was built in 90's, It is composed of Type II protected. The facility is divided into 45 smoke zones. The two facility generators do 100 % of the building. 1) Cummins 750 KW 2) Cat 600 KW	K 000		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/22/2024, 07/23/2024 and 07/24/2024 in the presence of facility management, it was	K 311	1. The facility failed to ensure that 3rd Floor stairwell doors #5 and #6 and 2nd floor stairwell door #5 exit stairwell access	7/29/24

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

Electronically Signed | 08/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

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MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE** **MORRISTOWN, NJ 07960**

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K 311	Continued From page 1 determined that the facility failed to ensure that 3 of 29 exit stairwell access doors were capable of maintaining the 1-1/2 hour fire resistance rating in accordance with NFPA 101:2012 edition, Section 19.3.1.6. This deficient practice was evidenced by the following: Along the three (3) day tour the surveyor inspected and conducted closure test of twenty-nine (29) exit access doors leading into exit stairways with the following results: Observations on 07/22/2024 revealed the following: 1) At approximately 10:09 AM, a closure test of the third (3rd.) floor stairwell #5 double doors was performed. When both doors were opened to a 90 degree opening to their frame and allowed to self-close, the left side door did not positive latch into its frame as required to maintain the exit stairwells fire rated construction. This test was repeated two (2) additional times with the same results. 2. At approximately 10:47 AM, a closure test of the third (3rd.) floor stairwell #6 double doors was performed. When both doors were opened to a 90 degree opening to their frame and allowed to self-close the left side door did not positive latch into its frame as required to maintain the exit stairwells fire rated construction. This test was repeated two (2) additional times with the same results. 3) At approximately 12:21 PM, a closure test of the second (2nd.) floor stairwell #5 double doors was performed. When both doors were opened	K 311	doors were capable of maintaining the 1 hour fire- resistance rating in accordance with NFPA 101:2012 edition, Section 19.3.1.6. Director of Maintenance immediately repaired the door latches to ensure compliance. 2. All residents have to potential to be affected by the deficient practice. 3. Education provided by the Regional Administrator to US FOIA (b)(6) on the components of the regulation with emphasis on ensuring exit stairwell access doors are capable of maintaining the 1 hour fire-resistance rating. Affirmed understanding of components of the regulation. 4. Audits of the 3 exit stairwell access doors will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for three months, to ensure that the exit stairwell access doors are capable of maintaining the 1 hour fire resistance rating. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance and Performance Improvement meeting for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

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K 311	Continued From page 2 to a 90 degree opening to their frame and allowed to self-close the right side door did not positive latch into its frame as required to maintain the 1-1/2 hour fire rated construction.. This test was repeated two (2) additional times with the same results. The US FOIA (b)(6) confirmed the finding at the time of observation. The US FOIA (b)(6) were informed of the deficient practice at the survey exit on 07/24/2024 at approximately 1:45 PM. NJAC 8:39- 31.2(e)	K 311		
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		7/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	**540 WEST HANOVER AVENUE** **MORRISTOWN, NJ 07960**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/24/2024 in the presence of US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that hazardous areas were protected with a fire-rated door to resist smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.5, 19.3.6.4,8.3, 8.5.1, 8.4,8.5.6.2 and 8.7. This deficient practice had the potential to affect all 261 residents and was evidenced by the following: An observation at 11:29 AM revealed a room with door frame # AG37V was being used to store combustible materials. The room was more than 50 square feet in size and contained combustible boxes, binders in boxes, plastic bags filled with folders, table carts with folders and binders on top, 3 tables, and 4 chairs. The room did not have a door installed to separate it from the exit corridor. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit	K 321	1. The facility failed to ensure that the hazardous area room with door frame #AG37V were protected with a fire-rated door to resist smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.5, 19.3.6.4,8.3, 8.5.1, 8.4,8.5.6.2 and 8.7. Director of Maintenance immediately cleared the area and removed the combustible storage to ensure compliance. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by the Regional Administrator to the US FOIA (b)(6) [redacted] on the components of the regulation with emphasis on ensuring hazardous areas are free from combustible materials. Affirmed understanding of the components of the regulation. 4. Audits of 3 hazardous areas will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months, to	

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K 321	Continued From page 4 conference at 1:45 PM. N.J.A.C 8:39-31.2(e)	K 321	ensure that the areas remain free of combustible materials. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of	K 324	1. The Director of Maintenance	7/29/24

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K 324	Continued From page 5 facility provided documentation on 07/22/2024 and 07/23/2024 in the presence of Facility Management, it was determined that the facility failed to ensure that 4 of 10 kitchen cooking equipment's Wet Chemical fire suppression systems nozzles were in the proper position to protect against fire in accordance with NFPA 101:2012 edition, Section 19.3.2.5.3*(10) and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 07/23/2024 at approximately 11:58 PM, revealed in the facility kitchen that the wet chemical fire suppression system (over the cooking equipment) had four (4) suppression spray nozzles aimed upward and not positioned to protect the cooking equipment. At 1:30 PM, a review of the kitchen wet chemical suppression system inspection dated 06/17/2024, revealed notations under the comments/ recommendations that read: "Upon arrival, 4 nozzles over ranges moved out of position. Put back into proper alignment but may get in the way of cooking operations." The US FOIA (B) (6) and US FOIA confirmed the finding at the time of observation. US FOIA (B) (6) were informed of the deficient practice at the Life Safety Code survey exit on 07/24/2024 at approximately 1:45 PM. NJAC 8:39-31.2(e) NFPA 96	K 324	immediately corrected the 4 wet chemical fire suppression nozzles to the proper downward position. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by Regional Administrator to the US FOIA (b)(6) [redacted] on the components of the regulation with emphasis on ensuring kitchen cooking equipment's Wet Chemical fire suppression systems nozzles were in the proper downward position to protect against fire hazardous areas are free from combustible materials. 4. Audits of the kitchen cooking equipment Wet chemical fire suppression systems nozzles will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months, to ensure that they remain in the proper downward position. Results of the audit will be reviewed by the Administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	
K 347 SS=F	Smoke Detection	K 347		7/29/24

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K 347	Continued From page 6 CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/23/2024 in the presence of the US FOIA (B) (6) [redacted] it was determined that the facility failed to ensure that space open to the corridor had smoke detection systems in accordance with NFPA 101 Life Safety Code:2012 Edition, Section 19.3.6.1.(7)(a). This deficient practice had the potential to affect all 261 residents and was evidenced by the following: An observation of the game room measuring approximately 594 square feet on the second floor at 1:10 PM, revealed the room had two sets of double doors open to the corridor that did not self-close and lacked a smoke detection system. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference at 1:45 PM on 07/24/2024.	K 347	1. The facility failed to ensure that space open to the corridor had smoke detection systems in accordance with NFPA 101 Life Safety Code:2012 Edition, Section 19.3.6.1.(7)(a). The Director of Maintenance immediately installed self-closures on the double doors. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by Regional Administrator to the US FOIA (b)(6) [redacted] on the components of the regulation with emphasis on ensuring space open to the corridor without a smoke detection system has self-closing doors. Affirmed understanding of the components of the regulation. 4. Audits of 3 spaces that open to the corridor will be conducted by Director of Maintenance/ designee weekly for 4 weeks, then monthly for two months, to ensure that they have a self-closure double door and/ or a smoke detection system in place. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	

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K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 07/22/2024, 07/23/2024 and 07/24/2024, in the presence of facility management it was determined that the facility failed to install automatic fire sprinklers sprinklers required by CMS regulation §483.90(a) physical environment to all areas in accordance with NFPA 101:2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations of the building starting at approximately 9:50 AM on 07/22/2024 and continued on 07/23/2024 and 07/24/2024 in the	K 351	1. The County Fire Marshal scheduled a date for installation of fire sprinkler coverage in the 1st floor staff lounge and scheduled replacement for the three down pendant type sprinkler heads in the ground floor cafe area. The Director of Maintenance immediately replaced the missing ceiling tiles in the ground floor cafe. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by Regional Administrator to the US FOIA (b)(6) [redacted] on the	7/29/24

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K 351	Continued From page 8 presence of the facility's US FOIA (B) (6) [redacted] revealed the following: An observation on 07/23/2024 at approximately 12:12 PM, revealed the inside of the second floor "Staff Lounge" 12 inch deep by 7-foot 6-inch wide closet had no evidence of fire sprinkler coverage. In an interview at the time, the US FOIA (B) (6) [redacted] confirmed the observation. An observation on 07/24/2024 at approximately 10:53 AM, revealed the 10-Foot 6-inch by 38-foot first floor "Cafe" was missing several of the rooms drop ceiling tiles. The room had three (3) down pendant type sprinkler heads in the room that were located 50 inches down from the decking above. The [redacted] and [redacted] confirmed the findings at the time of observations. The US FOIA (b)(6) [redacted] were informed of the deficient practice during the Life Safety Code survey exit on 07/24/2024 at approximately 1:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	components of the regulation with emphasis on ensuring that automatic fire sprinklers are properly in place to all areas and sprinkler coverage is maintained properly with ceiling tile protection. Affirmed understanding of the components of the regulation. 4. Audits of the facility to ensure 3 areas have automatic fire sprinkler systems will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months, to ensure that all areas have automatic fire sprinkler systems and sprinkler coverage is provided with ceiling tile protection. Results of the audits will be reviewed by the Administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance	K 353		7/29/24

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K 353	Continued From page 9 with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/22/2024 and 07/23/2024 in the presence of US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that the ceiling level was smoke resisting and failed to maintain the sprinkler system in accordance with NFPA 101:2012 Edition, Section 9.7.5, 9.7.7, 9.7.8, NFPA 25:2011 Edition, Section 5.2.1.1.5. These deficient practices had the potential to affect all 261 residents and were evidenced by the following: During the tour on 07/22/2024 between 11:30 AM and 3:35 PM in the presence US FOIA (B) (6) and [redacted], the surveyor observed the following: 1. The ceiling tile was not in place in soiled utility room opposite the 2D nurse's station.	K 353	1. The Director of Maintenance replaced missing ceiling tiles in soiled utility room opposite the 2D nurses station, replaced the missing ceiling tiles in the bathroom suite #1420, sealed the opening in electrical room next to the double door #9, sealed the opening in electrical closet in 1st floor day room, replaced missing ceiling tiles in IT storage room, closed opening in Activities storage closet, replaced missing ceiling tiles in the office next to Medical Records. The County Fire Marshal installed escutcheon plates in Room #2412 bathroom, Janitor closet next to room #2414, electrical closet E - 13, 1st floor nourishment station, and stair tower #8 on the 2nd floor. 2. All residents have to potential to be affected by the deficient practice.	

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K 353	Continued From page 10 2. Room # 2412 was missing the escutcheon plate in the ceiling in the bathroom. 3. The janitor closet next to room #2414 was missing escutcheon plate. 4. The electrical closet E-13 was missing escutcheon plate. 5. The first floor nourishment station was missing escutcheon plate. 6. The bath suite #1420 was missing 24 ceiling tiles. 7. The electrical room next to the double door # 9 had an opening in the ceiling. 8. Stair tower #8 on the second floor was missing an escutcheon plate. 9. The electrical closet in first floor day room had opening in the ceiling. In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observations. During the tour on 07/23/2024 between 9:30 AM and 3:30 PM in the presence US FOIA (b)(6) [redacted], the surveyor observed the following: 1. The IT storage room was missing 4 ceiling tiles. 2. The activities storage closet had 2-foot by 2-foot opening in the ceiling. 3. The office next to medical record was missing 2 (2-foot by 2-foot) ceiling tiles.	K 353	3. Education was provided by Regional Administrator to the US FOIA (b)(6) [redacted] on the components of the regulations with emphasis on ensuring that ceiling tiles are not missing and escutcheon plates are not missing. Affirmed understanding of the components of the regulation. 4. Audits of the facility to ensure three areas have ceiling tiles and escutcheon plates in place will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	

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K 353	Continued From page 11 In an interview at the time, the US FOIA (b)(6) [redacted] confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practices during the Life Safety Code exit conference at 1:45 PM on 07/24/2024. N.J.A.C 8:39-31.2(e) NFPA 25:2011	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/23/2024 in the presence of US FOIA (B) (6) [redacted] it was determined that the facility failed to: 1) Ensure that 4 of 108 Fire extinguishers observed, pressure gauge reading or indicator were in the operable range or position. 2) Maintain 1 of 108 fire extinguishers in proper working condition, as required by the NFPA 101:2012 Edition, Section 19.3.5.12, 9.7.4.1 and NFPA 10:2010 Edition, Section 7.2.2(3), 7.2.3. These deficient practices had the potential to affect all 261 residents and were evidenced by the following: An observation during the tour between 9:10 AM	K 355	1. The County Building Director immediately replaced the 4 extinguishers #55, #58, #83 and #102 that were in the overcharge position posing a risk for rupture. The County Building Director immediately replaced the 1 extinguisher on 3rd floor unit C that had the pressure needle in the red discharge zone. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by Regional Administrator to the US FOIA (b)(6) [redacted] on	7/29/24

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K 355	Continued From page 12 and 3:45 PM, in the presences of US FOIA (b)(6) of fire extinguishers #55, #58, #83 and #102 tags dated 07/1/ 2024, revealed the pressure gauge readings were on the overcharge position which poses a risk of rupture. On 07/22/2024 at approximately 11:24 AM, Surveyor #2 observed on the 3rd. floor "C-Unit" that the fire extinguisher facility ID #93 pressure indicating needle was in the RED discharge zone on the pressure gauge. In an interview at the time, the US FOIA (b)(6) confirmed the observation and US FOIA (b) stated that the vender will be coming tomorrow to replace the extinguishers. The facility's US FOIA (b)(6) was informed of the deficient practices during the Life Safety Code exit conference at 1:45 PM on 07/24/2024. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 10	K 355	the components of the regulation with emphasis on ensuring portable fire extinguishers are in operable range or position and in proper working condition. Affirmed understanding of the components of the regulation. 4. Audits of 5 fire extinguishers will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months, to ensure that they remain in operable range or position and in proper working condition. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These	K 363		7/29/24

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K 363	Continued From page 13 requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/22/2024 in the presence of US FOIA (B) (6) [redacted] it was determined that the facility failed to ensure that corridor doors were maintained to positively latch in the frame and resist the passage of smoke in accordance with NFPA 101:2012 Edition, Section 19.3.6.3. This deficient practice had the potential to affect all 261 residents and was evidenced by the following:	K 363	1. The Director of Maintenance immediately repaired the latch in rooms #[redacted], #[redacted], and #[redacted]. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by Regional Administrator to the US FOIA (b)(6) [redacted] on the components of the regulation with emphasis on ensuring that corridor doors latch into the frame and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 14 Observations during a facility tour between 11:20 AM and 3 :15 PM, revealed resident rooms #[NJ ex order], #[NJ ex order] and #[NJ ex order] did not latch into frame when tested by DM. In an interview at the time, the [US FOIA (B) (6)] and [US FOIA (B)] confirmed the observation. The facility's [US FOIA (B) (6)]r was informed of the deficient practice during the Life Safety Code exit conference at 1:45 PM on 07/24/2024.	K 363	resist the passage of smoke. Affirmed understanding of the components of the regulation. 4. Audits of the facility to ensure 3 corridor doors are maintained to positively latch in the frame will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/23/2024 in the presence of [US FOIA (B) (6)] and [US FOIA (B) (6)] it was determined that the facility failed to ensure that smoke barrier walls were maintained in	K 372	1. The Director of Maintenance immediately repaired the penetration going through the smoke barrier wall above doors #6 in the ceiling tile, the two holes through the smoke barrier wall above door #7 in the ceiling tile, and the	7/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

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K 372	Continued From page 15 accordance with NFPA 101:2012 Edition, Section 19.3.6.2.3, 8.5.6, 8.5.6.2, and 8.5.6.3. This deficient practice had the potential to affect all 261 residents and was evidenced by the following: An observation at 11:35 AM, in the presence of the US FOIA (B) (6) and US FOIA (B), revealed one-hole approximately 3/4-inch in diameter with 4 wires going through the smoke barrier wall above door #6 in the ceiling tile. In an interview at the time, the US FOIA (B) (6) and US FOIA (B) confirmed the observation. An observation at 11:48 AM in the presences of US FOIA (B) (6) and US FOIA (B), revealed two holes with one approximately 3-inches in diameter with 8 wires going through it and the second approximately 1-1/2-inches in diameter with 6 wires going through the smoke barrier wall above door #7 in the ceiling tile. In an interview at the time, the US FOIA (B), US FOIA and US FOIA (B) confirmed the observation. An observation at 11:55 AM in the presences of US FOIA (B) (6) and US FOIA (B), revealed one hole approximately 2-inches in diameter with 6 wires going through the smoke barrier wall above door #9 in the ceiling tile. In an interview at the time, the US FOIA (B) (6) and US FOIA (B) confirmed the observation. The facility's US FOIA (b)(6) was informed of the deficient practice during the Life Safety Code exit conference at 1:45 PM on 07/24/2024.	K 372	one hole going through the smoke barrier wall above door #9 in the ceiling tile. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by US FOIA (B) (6) [redacted] on the components of the regulation with emphasis on ensuring that the smoke barrier walls are maintained in accordance with NFPA regulations cited above. Affirmed understanding of the components of the regulation. 4. Audits of the facility to ensure 3 smoke barrier walls are maintained properly will be conducted by Director of Maintenance/designee weekly for 4 weeks, then monthly for two months. Results of the audits will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	

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	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

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K 372	Continued From page 16 N.J.A.C 8:39-31.2(e)	K 372		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/22/2024 and 07/23/2024 in the presence of US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B) (6) it was determined that the facility failed to ensure that residents room air conditioner (AC) units were maintained in safe operating condition in accordance with the National Fire Protection Association (NFPA) 90A. This deficient practice was identified for 4 of 158 observed and was evidenced by the following: During the tour on 07/22/2024 between 11:15AM and 3:20 PM in the presence of the US FOIA and US FOIA (B), the surveyor observed resident's room #NJ ex order and #NJ ex order AC unit filters were clogged and dirty. In an interview at the time, the US FOIA (B) (6) and US FOIA (B) confirmed the observation. During the tour on 07/23/2024 between 9:15 AM	K 521	1. The Director of Maintenance immediately replaced the air condition unit filters in room #NJ ex order, #NJ ex order, #NJ ex order, and #NJ ex order. 2. All residents have to potential to be affected by the deficient practice. 3. Education was provided by Regional Administrator to the US FOIA (B) (6) on the components of the regulation with emphasis on ensuring that the residents room air conditioner units are maintained in safe operating condition. 4. Audits of the facility will be conducted by the Director of Maintenance/designee to ensure 3 resident room air condition unit filters are cleaned and replaced weekly for 4 weeks, then monthly for two months. Results of the audit will be	7/29/24

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	315303	A. BUILDING **01** B. WING _____	**07/24/2024**

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K 521	Continued From page 17 and 3:15 PM in the presence of the US FOIA and US FOIA (B) (6) the surveyor observed resident rooms #[redacted] and #[redacted] AC unit filters were clogged and dirty. In an interview at the time, the US FOIA (B) (6) and US FOIA (B) confirmed the observation. The facility's US FOIA (B) (6) was informed of the deficient practice during the Life Safety Code exit conference at 1:45 PM on 07/24/2024. N.J.A.C 8:39-31.2(e)	K 521	reviewed by the Administrator monthly at the Quality Assurance Performance improvement meeting for 3 months.	
K 916 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 07/22/2024 and 07/24/2024 in the presence of facility management, it was determined that the facility failed to provide a remote annunciator panel for one (1) of two (2) emergency generator electrical systems to alert staff of the system's condition in accordance with National Fire Protection Association (NFPA) 99:2012, Section 6.4.1.1.17. This deficient practice had the	K 916	1. The County Building Director contacted the generator vendor to install an additional annunciator and ordered parts on 7/26/24, the second annunciator installation was completed by County contractor 9/6/24. 2. All residents have to potential to be affected by the deficient practice.	9/6/24

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K 916	Continued From page 18 potential to affect all residents and was evidenced by the following: In an interview on 07/22/2024 during at approximately 9:13 AM, the [US FOIA] stated the facility had two (2) emergency generators. One is a 600 KW and one is a 800 KW and the generator annunciator panel is located at the main entrance Security desk. During a tour of the building on 07/22/2024 with the facility [US FOIA (B) (6)] at approximately 10:00 AM, an inspection of the Main Entrance Security desk area was performed. The surveyor observed one Emergency Generator annunciator panel. At this time the surveyor asked the [US FOIA], where is the second generator annunciator panel. The [US FOIA] told the surveyor there is only one annunciator and there is no annunciator for the 2nd generator. The [US FOIA (B)] and [US FOIA] confirmed the findings at the time of observations. The [US FOIA (B) (6)] were informed of the deficient practice at the Life Safety Code survey exit on 07/24/2024 at approximately 1:45 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 916	3. Education was provided by [US FOIA (B) (6)] on the components of the regulation with emphasis on ensuring that the facility has an annunciator to monitor both facility emergency generators. Affirmed understanding of the components of the regulation. 4. Audits of the generator annunciator panels will be conducted by the County Building Director/designee to ensure both generators have enunciator alert panels to alert staff of the systems condition weekly for 4 weeks, then monthly for two months. Results of the audit will be reviewed by the administrator monthly at the Quality Assurance Performance Improvement meeting for 3 months.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315303 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/16/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0311	07/29/2024	LSC K0321	07/29/2024	LSC K0324	07/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0347	07/29/2024	LSC K0351	07/29/2024	LSC K0353	07/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	07/29/2024	LSC K0363	07/29/2024	LSC K0372	07/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0521	07/29/2024	LSC K0916	09/06/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/24/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO