

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>60a005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/07/2026</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SPRING HILLS AT MORRISTOWN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>17 SPRING PLACE</b> <b>MORRISTOWN, NJ 07960</b>
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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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ 00188874</p> <p>CENSUS: 99</p> <p>SAMPLE SIZE: 4</p> <p>The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs.</p> <p>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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/13/26

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00188874</p> <p>Based on interview and record review, it was determined that the facility failed to implement and enforce the policy titled "Disaster Plan For Fire". This deficient practice was evidenced by the following:</p> <p>On <sup>NJ Exec Order 26.4b</sup>, the Department of Health (DOH) received a Facility Reportable Event (FRE) (a form used by healthcare facilities to report incidents to the DOH) regarding a dumpster fire that occurred on <sup>NJ Exec Order 26</sup>. The FRE indicated that a resident witnessed the fire and notified a staff member who responded to the fire.</p> <p>On 1/7/26 at 9:45 a.m., the surveyor reviewed the fire and emergency policy and procedures provided by the Director of Maintenance (DOM).</p> <p>At 10:30 a.m., the surveyor interviewed Resident #1 regarding the dumpster fire that occurred on <sup>NJ Exec Order 26</sup>. The resident stated that he/she noticed the fire because it was <sup>NJ Exec Order 26.4b1</sup>. The resident stated that he/she notified a housekeeping employee who informed another employee about the fire before responding to the fire with a fire extinguisher.</p> <p>At 10:45 a.m., the surveyor interviewed the Director of Maintenance (DOM) regarding the fire that occurred in the dumpster. The DOM stated that he heard the fire announcement over the</p>	A 310		

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NAME OF PROVIDER OR SUPPLIER  <b>SPRING HILLS AT MORRISTOWN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>17 SPRING PLACE MORRISTOWN, NJ 07960</b>
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A 310	<p>Continued From page 2</p> <p>walkie-talkie and responded to the dumpster with a fire extinguisher to contain the fire. The DOM stated that 911 was called by an employee but he was not sure of who called 911.</p> <p>At 11:00 a.m., the surveyor interviewed the Executive Director (ED) regarding the dumpster fire. The ED stated that a former receptionist called 911 when she was notified over the radio regarding the dumpster fire.</p> <p>Further, the surveyor interviewed the ED regarding the first staff member not following the steps in the fire and emergency policy. The ED stated that she was not aware of who needed to report a fire first.</p> <p>The surveyor reviewed the fire and emergency policy titled, "Disaster Plan for Fire" dated 3/1/22, which revealed, "The staff member discovering a fire is to call 9-1-1, pull the fire alarm, and notify all other personnel prior to responding to the fire location."</p>	A 310		
A 537	<p>8:36-5.7(a)(1) General Requirements</p> <p>(a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following:</p> <p>1. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and</p>	A 537		

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A 537	<p>Continued From page 3</p> <p>resident care services of the facility or program;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00188874</p> <p>Based on interview and record review, it was determined that the facility failed to review the policy and procedures manual (PPM) annually. This deficient practice was evidenced by the following:</p> <p>On 1/7/26 at 9:45 a.m., the surveyor reviewed the fire and emergency policy and procedures provided by the Director of Maintenance (DOM), which revealed that the last revision of the policy was dated 3/1/2022.</p> <p>Surveyor further review of the PPM revealed that the PPM was last reviewed on 3/1/2022.</p> <p>At 10:15 a.m., the surveyor interviewed the DOM regarding the last revision of the fire and emergency procedure and policy manual dated 3/1/2022. The DOM stated that he did not know the policy and procedure manual needed to be updated annually.</p> <p>At 10:45 a.m., the surveyor interviewed the Executive Director (ED) regarding the annual review of the fire and emergency manual, dated 3/1/2022. The ED stated she was not aware of the annual policies update requirement.</p>	A 537		



## Morristown Spring Hills Community

Plan of Action

Executive Director: [redacted] NJ Exec Order 26.4b1

Date: 02/11/2026

received 2/12/26  
reviewed 2/13/26  
accepted 2/13/26

[redacted] NJ Exec Order 26.4b1

### Noncompliance:

The facility has failed to meet the following state health, safety, and quality regulations:

- Regulations/Tag 8:36-3.4(a)(1) A310
- Regulations/Tag 8:36-4.1(a)(22) A537

### Corrective Action – Deficiencies

#### 1) **Administration:** Regulations/Tag 8:36-3.4(a)(1) A310

Element #1 Resident #1 identified in the deficient practice still resides within the community.

Element #2 No residents were directly affected by the deficient practice.

Element #3 The Executive Director will ensure that all staff members will receive comprehensive training on the facility's policies and procedures on fire protocol. This training will be ongoing and include regular updates to keep staff informed of any changes or revisions.

**Completion Date for the deficiency is 02/15/2026.**

Element #4 The Executive Director and the Business office Manager will conduct full audits to ensure all staff are trained upon hire and annually.

#### 2) **General Requirements:** Regulations/Tag 8:36-5. 7(a)(1) A537

Element #1 There were no specific residents named with this deficiency.

Element #2 No residents were directly affected by the deficient practice.





Element #3 The Executive Director will ensure that the fire and emergency policy and procedures are adhered to and reviewed at least annually. All staff members will receive comprehensive training on the facility's policies and procedures. This training will be ongoing and include regular updates to keep staff informed of any changes or revisions. Training began on 2/1/2026 and will be completed by 2/15/2026. All staff to be retrained on an annual basis.

Element #4 The Executive Director, through collaboration with the Corporate Compliance Officer, will annually evaluate the effectiveness of the Policies and Procedures to identify areas for improvement. Use this feedback to revise and refine the policies and procedures, as needed, to better meet the needs of the residents and promote compliance. **The Completion date for the deficiency is 02/28/2026.**

Department of Health Surveyor **NJ Exec Order 26.4b1**

**NJ Exec Order 26.4b1**

Executive Director Signature

*2/12/26*  
Date

received 2/12/26  
reviewed 2/13/26  
accepted 3/13/26

**NJ Exec Order 26.4b1**



## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 60a005	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/13/2026	Y3
NAME OF FACILITY SPRING HILLS AT MORRISTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 17 SPRING PLACE MORRISTOWN, NJ 07960		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310	Correction	ID Prefix A0537	Correction	ID Prefix	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.7(a)(1)	Completed	Reg. #	Completed
LSC	02/15/2026	LSC	02/28/2026	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/7/2026		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

## STATE FORM: REVISIT REPORT

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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/7/2026		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		