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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris View Healthcare Center	540 West Hanover Avenue Morristown, NJ 07960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #: NJ00180247 Based on interview, record review, and review of facility documents on 05/06/2025 and 05/12/2025, it was determined that the facility failed to report an allegation of misappropriation on 08/10/2024 to the New Jersey Department of Health (NJDOH) being made for a resident (Resident #1) missing items [four vapes]. This was observed in 1 of 1 resident reviewed for misappropriation. This deficient practice was evidenced as follows: According to Resident #1's admission Record (AR), Resident was admitted to the facility with the following diagnoses which included but not limited to: Achalasia of cardia [swallowing disorder], narcolepsy with cataplexy [loss of muscle tone associated with excessive sleepiness], anxiety disorder, post traumatic stress disorder, major depression, and bipolar disorder. Review of Resident #1's Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of a resident's functional capabilities and helps the facility identify residents' health problems, dated 03/06/2025, the Resident showed a Brief Interview of Mental Status (BIMS) of 14 indicating that Resident's cognition was intact. (continued on next page)

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

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

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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris View Healthcare Center	540 West Hanover Avenue Morristown, NJ 07960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's documentation Investigational Summary (IS) completed and signed by Director of Nursing (DON) and Administrator on 8/12/24. The IS has the Resident #1's name [redacted] and Date of 8/10/2024; Overview: Missing Item: 4 vapes. The IS reflected the Description of the Event as follows: on 8/10/24 [Resident #1's roommate (Resident #8)] informed Resident #1 that Licensed Practical Nurse (LPN #1) entered the room, Resident #8 unsure of the exact time. Resident #8 stated that LPN #1 came into the room [number] and went to Resident #1's side of the room. She [Resident #8] was able to see LPN #1 in the mirror. Resident #8 stated that LPN #1 went to Resident #1 nightstand and black plastic organizers and opened them. Then exited the room. Resident #1 notified [local town] Police Department (PD) who came to the facility and interviewed Resident #1. Resident #1 informed them that her vapes were missing from her personal belongings. Resident #1 did not notify staff at that time. Sunday 8/11/24 approximately 10:45am [local town] PD arrived at the facility. Obtained a statement from LPN#1. She denied taking the vapes. Monday 8/12/24 at approximately 7am LPN #1 found missing vapes in the soiled utility room in a plastic bag. LPN #! Notified Social Services that the missing items were found. She [LPN #1] turned the vapes into the Social Worker (SW) [name redacted]. SW secured the vapes in a safe place and informed Resident #1 that they were found. Resident #1 accused LPN #1 of stealing the vapes from her room. The DON [name redacted] instructed LPN #1 that she will no longer be the nurse assigned to [room number] to minimize the potential of future accusations. Resident #1 informed of the plan moving forward and affirmed understanding. Video footage reviewed by the DON and Administrator, Licensed Nursing Home Administrator (LNHA), the video reveals on 8/10/24 at approximately 12:50pm LPN #1 entered room [number] where she remained until 12:54pm. LPN #1 exited room [number] with both hands visible with no items in either hand. LPN #1 walked down the hallway and went to the nurse's station. At the nurse's station LPN #1 obtained her personal bag. Unable to see if any items were put in or removed from her bag. 8/12/24 at approximately 6:35am video reveals LPN #1 enter the [ID] Unit and begin to do rounds of the low hall rooms. LPN #1 dropped her personal belongings at the desk and took soiled plastic bags from her morning rounds in the soiled utility room to dispose them. LPN #1 exited the soiled utility room with a plastic bag and went to nurse's station. The IS further revealed that interview with LNHA, DON, and LPN #1: LPN #1 stated Resident #1 asked her about her inhaler versus aerosol orders while at the nursing station. LPN #1 stated she advised she would reached out to Resident #1's MD [doctor][name redacted] which LPN #1 did and communication was verified. Resident #1 came back to LPN #1 because LPN #1 followed up on receiving orders for her on Friday. LPN #1 further stated she went to Resident #1's room to inform her that she was still waiting for MD to callback. Resident #1 was not in her room. Her roommate [Resident #8] was lying in bed. Resident #1 at times had headphones on so LPN #1 looked behind the curtain to see if she was there and possible did not hear LPN #1 enter. While walking out, Resident #1 roommate [Resident #8] was asking LPN #1about her remote and channels. When LPN #1 left the room, she saw Resident #1 in the hallway (high side) providing her with the update. Resident #1 said thank you. The IS revealed under Intervention: Notifications: Primary nurse, MD [name redacted], Resident, [local town] PD; Staff nurse will not be assigned to room [number]; Staff interviews; Resident interviews. (continued on next page)

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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris View Healthcare Center	540 West Hanover Avenue Morristown, NJ 07960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In the IS, the Summary of Investigation was documented as follows: Investigation reveals there is no physical or visual evidence of vapes being taken or possessed by LPN #1. Vapes were found in the soiled utility room amongst soiled linens and given to Social Services on Monday 8/12/24. Resident #1 was informed the vapes were located and secured by Social Services. Social Services will follow up with Resident #1 as needed. LPN #1 will not be assigned to room [number] to minimize the potential of any future accusations. LPN #1 affirmed understanding. Review of Resident #1's progress notes (PN) did not contain documentation of the said incident of allegation of misappropriation against LPN #1 as indicated in the IS made by the facility on the above-mentioned dates. On 05/06/2025 at 4:27pm, the Surveyor interviewed the Assistant Director of Nursing (ADON) and the LNHA. The ADON was the acting DON at present. The LNHA affirmed the allegation of misappropriation incident was not reported to the New Jersey Department of Health (NJDOH) by the previous administration. LNHA further stated that the incident was an allegation and the vapes were found afterwards. The ADON stated that according to previous DON the investigation result was not substantiated even the Court dropped it. When asked by Surveyor to provide documentations to support their statement, though the ADON stated in their inquiry with the local town PD that they sent result of investigation to Resident #1, the facility was unable to provide pertinent documentations or video footages. Review of the facility's policy titled, Abuse Prevention Program, revised 01/2025, under their Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation, this includes but not limited to . Under Policy Interpretation and Implementation: .6. Identify and assess all possible incidents of abuse; 7. Investigate and report any allegations of abuse within timeframes as required by federal requirement . NJAC 8:39-9.4(f)

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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris View Healthcare Center	540 West Hanover Avenue Morristown, NJ 07960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint#s: NJ00179392, NJ00184406, NJ00184468, NJ00180247 Based on interviews, medical record review, and review of other pertinent facility documentation on 05/06/2025 and 05/12/2025, it was determined that the facility failed to: (a) update the care plan (CP) with interventions for a resident [Resident #7] when the diet consistency of was observed changed by a family member and (b) implement and revise care plan (CP) interventions for a resident (Resident #1) who was a smoker while in the facility and had history of smoking incidents. This deficient practice was identified for 2 of 8 residents reviewed for care plans and was evidenced by the following: According to the admission Record [AR] Resident #7 was admitted to the facility with the diagnoses which included, but were not limited to Cerebral Palsy [a group of disorders that affect movement, posture, and muscle coordination due to the abnormal brain development or damage to the developing brain], Aphasia [impairment in person's ability to comprehend or formulate language because of damage to specific brain region], and Quadriplegia [paralysis that affect all a person's limbs and body from the neck down.] According to the Quarterly Minimum Data Set [MDS] an assessment tool dated 03/20/2025 Resident #7 was not able to complete the assessment. Staff assessment indicated Resident #7 had short-term and long-term memory problems. According to Resident #7's CP regarding the father interferes with his/her care that on 11/12/2024 he was noted pouring thin liquid s into thickened liquids from kitchen tray and yelling at staff stating, this is too thin. The CP revealed that there were no new interventions related to the tampering of the consistency of the liquids. On 05/06/2025 at 3:54 P.M., the surveyor interviewed the Director of Nursing [DON], who stated that It would be best practice to update interventions post incident. The DON explained that the care plans are updated as needed and quarterly. The DON also stated that the Nursing Supervisor [NS] would update a care plan post incident. When the surveyor asked the DON if Resident #7's care plan looked updated post incident she stated, I would have to update myself on that. According to Resident #1's admission Record (AR), Resident was admitted to the facility with the following diagnoses which included but not limited to: Achalasia of cardia [swallowing disorder], narcolepsy with cataplexy [loss of muscle tone associated with excessive sleepiness], anxiety disorder, post-traumatic stress disorder, major depression, and bipolar disorder. Review of Resident #1's CP with Date Initiated:08/21/2023 revealed: Focus: [Resident #1 name] is a smoker: (continued on next page)

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	05/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morris View Healthcare Center	540 West Hanover Avenue Morristown, NJ 07960

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Resident #1 [name] was observed smoking in a restricted area on 10/09/23. Smoking privileges has been suspended for 1 day. Privileges will be reinstated on 10/11/23 with date initiated on 08/21/2023 and revision on 06/29/2024. Resident #1's CP interventions included but not limited to the following: -Smoking supplies are stored according to facility policy; staff hold and distribute. Date Initiated: 08/21/2023. On 08/10/2024, Resident #1 was missing four vapes from the bedside table and allegedly accused a staff to have taken it according to Resident #1's room mate (Resident #8) who was in the room and witnessed the incident. On 08/11/2024, Resident #1 called the local Police Department (PD) to report the incident. The allegation was known to the facility on [DATE] and the facility investigated. On 05/06/2025 at 1:41pm, the Surveyor interviewed the Social Worker (SW) regarding Resident #1. SW affirmed that Resident #1 was a smoker and utilized vapes. On 05/06/2025 at 4:27pm, the Surveyor interviewed the Assistant Director of Nursing (ADON) and the Licensed Nursing Home Administrator (LNHA). Both LNHA and ADON affirmed that Resident #1 was a smoker and utilized electronic cigarettes [vapes]. On 05/12/2025 at 4:21pm, the Surveyor interviewed the ADON who stated the Recreation Department held the lighters for the smokers. ADON further stated the smoking area was the back patio and other place than that would be considered a restricted area. Review of the facility's policy Care Plans, Comprehensive, Person-Centered reviewed /revised 02/2025 revealed under Policy Statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Under Policy Interpretation and Implementation, 8(g)-incorporate identified problem areas, 8(h)-incorporate risk factors associated with identified problems, and 10-Identifying problem areas and their caused and developing interventions that are targeted and meaningful to the resident are the endpoint of an interdisciplinary process. NJAC8:39-11.2 [e] [1][2]