Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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	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

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38327 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 the lunch food truck parked in front of the nursing station of 3D 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 Certified Nursing Aide (CNA) enter the 3D 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 3D unit dining area during mealtime the Registered Nurse (RN) came to the dining room. The surveyor asked the RN why Resident #105 had no lunch tray and was not being served at the same time as the other two residents on the same table. The RN stated that the CNA 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 RN 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 CNA received and set up the lunch tray of Resident #105 in the 3D dining room. On 7/12/24 at 10:27 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above concerns. On 7/12/24 at 12:41 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The surveyor notified the IP/RN of the above concerns. The IP/RN stated that the resident at the same table should have served at the same time. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Dining Environment Policy with a reviewed/revised date of February 2024 that was provided by the LNHA, 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 LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator for an Exit Conference. The facility did not provide additional information and did not refute the findings. N.J.A.C. 8:39-4.1(a)12

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Develop and implement policies and procedures to prevent abuse, neglect, and theft.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48423

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 Certified Nursing Assistant (CNA), hired 02/06/24. 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 (LPN), hired 02/16/23. There was no evidence of the reference checks from past employers in the file.

Review of S#5, the Registered Nurse (RN), hired on 3/12/24. The NJDCA license printout was dated 7/09/24. 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).

39885

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 Licensed Practical Nurse, hired on 12/21/23, had a NJDCA license verification printout (used to verify the status of a license for license verification) dated 12/27/23. 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 Recreation Aide, hired on 3/06/23, did not have documented evidence in their employee that a reference was obtained.

Review of S#8, an Occupational Therapist, hired on 12/04/23, did not have documented evidence in their employee that a reference was obtained.

Review of S#9, a Registered Nurse/MDS, hired on 6/28/23, did not have documented evidence in their employee that a reference was obtained.

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F 0607

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Review of S#10, a Unit Clerk, hired on 01/03/23, did not have documented evidence in their employee that a reference was obtained.

The review for criminal background check for one of the five new employees revealed the following:

Review of S#10, hired on 01/03/23, had a Background Screening Report (BSR) dated 01/05/23. The BSR was ordered and reported after the date of hire. A review of a Time & Attendance-Employee Punch History form in the file indicated S#10 punched in and out on 01/03/23, 01/04/23 and 01/05/23.

On 7/16/24 at 10:53 AM, in the presence of the survey team, the surveyor interviewed the Director of Human Resources ([NAME]) via telephone on speaker regarding the process for new employee hire. The [NAME] 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 [NAME] when the license was verified. The [NAME] 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 [NAME] that S#6's license verification was done after the doh. The [NAME] confirmed that the license verification should have been done on 12/21/23 and that she was not the person that did the file. The surveyor also notified the [NAME] that S#1's did not have a license verification. The [NAME] 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 [NAME] that S#5's license verification was done months after their doh. The [NAME] 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 [NAME] did not have the verification.

At that same time, the surveyor asked the [NAME] the process for reference checks. The [NAME] 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 fresh out of college, they could only provide one. The surveyor asked the [NAME] the process for criminal background check. The [NAME] stated that it should be done upon hire. The surveyor notified the [NAME] that S#10's BSR was dated 01/05/23, two days after the doh. The [NAME] stated that S#10 started in July. The surveyor then notified the [NAME] that documentation in the file had S#10 punched in on 01/03/23. The [NAME] 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 Licensed Nursing Home Administrator (LNHA) 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 LNHA 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 Director of Nursing (DON), the LNHA stated that sometimes the doh was not the date the employee started in the facility.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 38327 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. 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 5/23/24 revealed that the MDS was completed on 6/24/24 and was submitted and accepted on 7/08/24. A review of Resident #135's annual MDS with an ARD of 10/12/23 was completed on 10/27/23 and was submitted and accepted on 10/30/23. 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 MDS Coordinator/RN (ptMDSC/RN). The ptMDSC/RN 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 ptMDSC/RN of the above findings and concerns. The ptMDSC/RN 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 5/02/24 revealed that the MDS was completed on 6/02/24 and was submitted and accepted on 6/03/24. 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. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 7/15/24 at 11:53 AM, the survey team met with Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above findings. The DON stated that the MDS Director acknowledged the concern with late completion and submissions of MDS. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator 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)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assure that each resident's assessment is updated at least once every 3 months. 38327 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 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 11/23/23, the quarterly assessment was not completed until 12/12/23, 19 days later, and was submitted 12/15/23. 2. Resident #135's ARD was on 4/04/24, the quarterly assessment was not completed until 4/30/24, 26 days later, and was submitted 5/01/24. Resident #135's ARD was on 01/11/24, the quarterly assessment was not completed until 01/28/24, 17 days later, and was submitted on 02/05/24. On 7/12/24 at 8:56 AM, the surveyor interviewed the part-time MDS Coordinator/RN (ptMDSC/RN). The ptMDSC/RN informed the surveyor that the 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 ptMDSC/RN of the above findings and concerns. The ptMDSC/RN 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 Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above findings. The DON stated that the MDS Director acknowledged the concern with late completion and submissions of MDS. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator for an Exit Conference. The facility did not provide additional information and did not refute the findings. NJAC 8:39-11.1

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 38327 REPEAT DEFICIENCY Based on the interview, record review, and review of pertinent facility documentation it was 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 inclusion of body myositis (an inflammatory condition of the muscles that causes weakness), adjustment disorder with depressed mood, ulcerative colitis (a chronic, inflammatory bowel disease that causes inflammation in the digestive tract), and functional quadriplegia (complete immobility due to severe disability or frailty caused by another medical condition). 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 7/04/24 showed in Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 15 out of 15 which indicated that the resident's cognition was intact. The QMDS 7/04/24 Section J Health Conditions showed that the assessment was done by per diem MDS/Registered Nurse (pdMDS/RN). The pdMDS/RN interviewed the resident if the resident had pain in the last five days and the resident responded No. Further review of the above QMDS 7/04/24 revealed that the pdMDS/RN signed and completed Section J on 7/14/24 at 6:28 PM. On 7/15/24 at 9:51 AM, the surveyor interviewed the MDS Coordinator RN (MDSC/RN). The MDSC/RN stated that the pdMDS/RN works 100% remotely, which meant that the pdMDS/RN does not go to the facility to assess and see the resident. The MDSC/RN further stated that the pdMDS/RN does all computer work remotely and acknowledged that the pdMDS/RN does not talk to the resident. The MDSC/RN also stated that the pdMDS/RN 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 MDSC/RN, how the pdMDS/RN was able to accurately answer the questions in Section J of the MDS if the pdMDS/RN was not at the facility to interview the resident. The MDSC/RN initially did not respond and later on, stated that she (MDSC/RN) was the one who interviewed the residents for Section J. The surveyor then asked the MDSC/RN, if she was the one who interviewed the resident for Section J why the MDSC/RN did not sign and complete Section J. The MDSC/RN stated and acknowledged that it was considered inaccurate MDS because the pdMDS/RN did not interview the resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/15/24 at 11:53 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the concern regarding Resident # 135's inaccurate MDS for Section J of ARD 7/04/24 done by pdMDS/RN who did not come to the facility to interview the resident as confirmed by the MDSC/RN. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator 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. 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 . 46049 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 included, but were not limited to, Alzheimer's Disease, anemia, and anxiety disorder. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive MDS, with an ARD of 4/18/24, under section B, B0700, Makes Self Understood and B0800, Ability to Understand Others it was coded that the resident 2. Sometimes understands. Under Section C, C0100, Should Brief Interview for Mental Status (C0200-C0500) be Conducted? it was coded 0. No (resident is rarely/never understood). Under Section O, Special Treatments, Procedures, and Programs, the resident was not coded as receiving hospice care. A QMDS with an ARD of 6/13/24, under section B, B0700, Makes Self Understood and B0800, Ability to Understand Others. Section C, C0100, Should Brief interview for Mental Status documented 0. No (resident is rarely/never understood). Under Section O, Special Treatments, Procedures, and Programs, the resident was not coded as receiving hospice care. A review of the Order Summary Report included a physician's order dated 4/11/24 read, admitted to [Company Name] hospice 4/11/24. On 7/10/24 at 12:15 PM, the surveyor interviewed the MDSC/RN about completing MDS assessments' section B and section C. The MDSC/RN stated that if a resident was coded as being able to sometimes understand in Section B, a BIMS should be attempted for a resident in Section C. 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 received hospice care and acknowledged it should have coded at the time the assessment was done. Furthermore, the MDSC/RN stated for sections B and C that two different staff had completed each section at different times. The MDSC/RN added that the staff who completed section B was fluent in the resident's primary language. The surveyor asked about translation for the resident with staff who did not speak their primary language and if a BIMS should have been attempted as the resident was coded as sometimes understood in Section B. She stated the resident's cognitive status varied and was different when interviewed by both staff. The MDSC/RN provided no further response. On 7/12/24 at 10:37 AM, the surveyor notified the LNHA and DON 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. 49078 3. The surveyor reviewed Resident #198's medical record including the MDS which revealed the following discrepancy: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the AR, Resident #198 was admitted to the facility with the diagnoses that included but were not limited to: type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), peripheral vascular disease (a slow and progressive disorder of the blood vessels), and polyneuropathy (damage to multiple nerves). A review of Resident #198's QMDS with an ARD of 6/13/24 showed in Section C a BIMS score of 13 out of 15 which indicated that the resident's cognition was intact. The QMDS 6/13/24 Section J showed that the assessment was done by pdMDS/RN. The pdMDS/RN interviewed the resident if the resident had pain in the last five days and the resident responded Yes and that the pain intensity was 3. Further review of the above QMDS 6/13/24 revealed that the pdMDS/RN signed and completed Section J on 6/19/24 at 11:45 PM. NJAC 8:39-11.2(e)(1,2)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. 38327 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.) specify a site for a pain medication patch for one (1) of one (1) resident, Resident #316 reviewed for pain management 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 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 included but were not limited to cellulitis (a serious deep infection of the skin caused by bacteria) of the right lower limb, hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone) unspecified, major depressive disorder recurrent unspecified, unspecified sequelae of other cerebrovascular disease (stroke), and other seizures (a sudden, uncontrolled burst of electrical activity in the brain). 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 4/27/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident had moderately impaired cognition. A review of the Order Summary Report (OSR) for June 2024 reflected a physician's order (PO) with an order date of 6/09/24 for Metoprolol Succinate ER (extended-release) tablet (tab) 25 mg (milligram) give one tab by mouth one time a day for HTN (hypertension, elevated blood pressure) hold for SBP (systolic blood pressure) less than 100 and pulse less than 60. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The above orders for Metoprolol were plotted in the electronic Medication Administration Record (eMAR) for June 2024 and were administered by nurses from 6/10/24 through 6/14/24 at 8:00 AM. There were no SBP and pulse documented in the June 2024 eMAR when the medication (med) Metoprolol was administered. On 7/10/24 at 11:41 AM, the surveyor interviewed the Registered Nurse (RN) in the 3 D unit. The surveyor asked the RN what was the facility's practice with regard to residents with orders for blood pressure medications (meds) with parameters. The RN stated that she checked blood pressure (BP) first prior to administering the BP med and documented it in the eMAR as ordered. At that same time, the surveyor notified the RN of the above findings that on 6/10, 6/11, 6/12, 6/13, and 6/14/24 Resident #106's Metoprolol was administered and there was no SBP and pulse documented as ordered. The RN admitted that she was the nurse on 6/10, 6/12, 6/13, and 6/14/24 who administered the med while the RN checked the electronic record. She further stated that she did not know why there was no documented SBP and pulse on those days. On 7/10/24 at 12:20 PM, the surveyor notified the Director of Nursing (DON) regarding the above findings. On 7/12/24 at 10:27 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. 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 LNHA and DON. The DON 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 included but was not limited to; COVID-19, spinal stenosis (happens when the space inside the backbone is too small), cerebral infarction (stroke), and unsteadiness on feet. The CMDS with an ARD of 9/21/23, reflected that Resident #316 scored a 13 out of 15 on the BIMS which indicated that the resident was cognitively intact. Further review of the MDS reflected that the resident complained of pain frequently. The OSR revealed a PO with a start date of 9/15/23 for Lidocaine External Patch 5% (Lidocaine) apply to skin topically every 24 hours for pain management. Further review of the above order for Lidocaine showed that the PO did not include the order for where to apply the patch. On 7/10/24 at 9:15 AM, the surveyor interviewed the DON who stated that she had been employed by the facility since 2020. The DON stated that if the resident was ordered a Lidocaine patch 5% then a location for patch placement should be specified in the order to assure that the correct pain site was being treated. The DON confirmed that the Lidocaine patch ordered 9/15/23, was not a complete order and did not specify where on the body the patch was to be applied. At that same time, the DON explained that the only way a nurse would know where to apply the patch was to ask the resident or read the resident's medical history. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 7/15/24 at 11:53 AM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above findings. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator for an Exit Conference. The facility did not provide any additional information and did not refute the findings. NJAC 8:39-11.2(b)

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F 0661

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.

38327

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 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 diagnoses that included but were not limited to cellulitis (a serious deep infection of the skin caused by bacteria) of the right lower limb, hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone) unspecified, major depressive disorder recurrent unspecified, unspecified sequelae of other cerebrovascular disease (stroke), and other seizures (a sudden, uncontrolled burst of electrical activity in the brain).

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 4/27/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident had moderately impaired cognition. The CMDS Section Q Participation in Assessment and Goal Setting included that the resident's overall goal plan was to be discharged in the community.

A review of the Order Summary Report (OSR) for June 2024 reflected a physician's order (PO) with an order date of 6/13/24 for the resident's discharge (d/c) on 6/14/24.

The Discharge Instructions and Summary with a lock date of 6/14/24 revealed a list of medications (meds) that included but was not limited to Aspirin EC (enteric-coated) tablet (tab) 81 mg (milligram) to give one tab by mouth two times a day for CAD (coronary artery disease, a condition that affects the heart) with a meal.

The latest Physician's PN dated 6/06/24 showed that the resident was continued on Aspirin EC 81 mg by mouth daily. The 6/06/24 Physician's PN also included the plan to d/c the resident home with homecare.

A review of the handwritten prescription (Rx) of meds dated 6/13/24 and signed by the Physician included the med ASA (aspirin) EC 81 mg by mouth QD (quaque die, which means, once a day).

On 7/10/24 at 11:41 AM, the surveyor interviewed RN#2 in the 3D unit. The surveyor notified the RN of the above concern regarding the discrepancy between the Discharge Instructions and Summary med list for ASA 81 mg EC twice a day while the Rx handwritten and signed by the Physician including the Physician's PN listed ASA 81 mg EC to be given QD.

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 RN what should the nurse do if there were discrepancies with the Discharge Instructions Summary med list and Rx that was provided by the Physician and what the Physician documented in PN. The RN stated that the nurse should have called the Physician and clarified the order. On 7/10/24 at 12:20 PM, the surveyor notified the Director of Nursing (DON) regarding the above findings. On 7/10/24 at 12:31 PM, the surveyor interviewed and notified the Physician of the above findings. The Physician confirmed that she provided the Rx on 6/13/24 for ASA 81 mg EC once a day. She further stated that the resident should take the ASA 81 mg EC once a day. On 7/12/24 at 10:27 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON. 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 LNHA and DON. The DON stated that she provided in-service regarding meds reconciliation. The DON 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 01/2024 that was provided by the LNHA 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 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 LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator for an Exit Conference. The facility did not provide additional information and did not refute the findings. NJAC 8:39-36.1(b)(c)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 39885 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 conclusion for root cause analysis and b.) a new non pharmacological intervention was implemented after each fall for one (1) of three (3) residents reviewed for falls (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 seated in a recliner chair in the 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; restlessness and agitation, dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and hypertension (high blood pressure). 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 cognitive skills for daily decision making was moderately impaired (decisions poor; cues/supervision required). The individualized Care Plan (CP) reflected a focused area with an initiated date of 01/29/24, of Resident #227 was at risk for falls r/t (related to) deconditioning. Interventions included: anticipate and meet resident's needs; follow facility fall protocol; 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 actual fall which listed several dates that the resident fell . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/09/24 at 11:38 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process for a fall. The LPN stated that the supervisor would be notified and resident would be assessed and if it was unwitnessed neuro checks would be performed. She added that she would initiate an incident report and an investigation would be done. The LPN stated that an intervention would be put in place to try to prevent another fall and that the unit manager would place it on the care plan. On 7/09/24 at 12:52 PM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) any incident/investigation for Resident #227. On 7/10/24 at 9:05 AM, the surveyor reviewed the facility provided incident investigations for falls which included the following: Unwitnessed Fall 3/05/24: Nursing Description: resident found sitting on the floor in dayroom. There was no documented conclusion of the investigation for the root cause of the fall. Attached to the incident report was a copy of the care plan with the following updated intervention: 3/05/24 Recreation screen for diversional activities with an initiated date of 3/06/2024. Unwitnessed Fall 3/27/24: Nursing Description: while resident in the day room, eating breakfast he/she slid out of wheelchair (w/c) and fell . 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: 3/27/24: Dycem (mat to prevent sliding) in place at all times. Unwitnessed Fall 4/25/24: Nursing Description: during afternoon med pass (medication administration for the unit), writer heard a scream, when writer looked in the direction of the day room resident was on the floor on his/her back in front of his/her w/c intervention. There was no documented conclusion of the investigation for the root cause of the fall. Attached to the incident report was a copy of the care plan with the following updated interventions: 1. 4/25/24: B/L (bilateral) hip x-ray ordered with an initiated date of 4/25/2024 2. 4/25/24: Psychiatric (psych) consult with an initiated date of 5/03/2024. There was no non-pharmacological intervention (npi- any type of healthcare intervention which is not primarily based on medication) implemented to attempt to prevent an additional fall. Unwitnessed Fall 6/04/24: Nursing Description: around 11:15 PM, while aid was doing rounds, resident observed on his/her floor mat by his/her bed. There was no documented conclusion of the investigation for the root cause of the fall. Attached to the incident report was a copy of the care plan with the following updated intervention: 6/04/24: psych re-consult for restlessness at bedtime with an initiated date of 6/05/2024. Also attached to incident documentation was a nursing progress note with an effective date of 6/04/24 that was created on 6/25/24 (a late entry) which included the following: consulted with psych about resident restlessness during the night, advised for staff to use PRN (as needed) Lorazepam (a benzodiazepine which works by slowing activity in the brain to allow for relaxation). There was no npi implemented to attempt to prevent an additional fall. There was not a different intervention implemented, the same intervention that was implemented after the last fall was used again. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/10/24 at 10:33 AM, the surveyor interviewed the Unit Manager (UM) of 1 A (UM1A) regarding the process for a fall. The UM1A stated that the process for a witnessed fall was to interview aids, nurses and the resident and write an incident report which was given to the Director of Nursing (DON) and Assistant DON (ADON). She added that an investigation was done by the team and a conclusion or root cause was done by the DON and ADON. The UM1A 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 fall. 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 fall. On 7/10/24 at 10:46 AM, the surveyor interviewed the ADON regarding the process for an unwitnessed fall. The ADON stated that for a fall after assessment, and notifications and administration of any orders, an incident report was initiated by the nurse. She added that she and the DON 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 unwitnessed fall there was no conclusion just an intervention on the care plan. The ADON 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 fall. The ADON stated that if a resident was having difficulty sleeping then they would do a psych consult. She added that npi would be tried and that if that did not work then a pharmacological intervention would be done. On 7/10/24 at 11:13 AM, the surveyor interviewed the DON regarding the process for unwitnessed falls. The DON 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 DON 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 UM1A regarding Resident #227 falls and interventions that were implemented on the care plan. The UM1A stated that a psych consult 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 npi was implemented. The UM1A stated that the psych consult was a npi for med review when a med can cause a fall and the med could be changed. The surveyor then asked the UM1A about the 6/04/24 intervention which was a psych reconsult. The UM1A stated that she needed to review the resident's record. On 7/11/24 at 12:29 PM, the UM1A stated that for the 4/25/24 fall the intervention was a psych consult and the recommendation was to encourage staff to use the prn med which was maybe ativan for restlessness and anxiety. The UM1A then stated that for the 6/04/24 fall the intervention was to be seen by psych and the recommendation was to discontinue the prn med and to make the Ativan a standing order for qid (four times a day). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at 12:45 PM, the surveyor interviewed the DON. The DON 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 DON stated that 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 DON about the 4/25/24 fall and the intervention of psych consult and if a npi was put in place. The DON stated that a PT/OT (physical therapy/occupational therapy) screen was done. The surveyor then asked the DON about the 6/04/24 fall and the same intervention of psych consult and if a npi was put in place. The DON stated that a repysch consult was an intervention and that it was a npi since it could be a med review for a possible GDR (gradual dose reduction). She then added that the psych consult could recommend npi's. The surveyor asked the DON if the psych consult made any npi recommendations. The DON stated that she would have to check. On 7/12/24 at 10:07 AM, the surveyor interviewed the DON. The DON stated that the interdisciplinary team (IDT) would meet in morning meeting to discuss a resident's fall but that they do not document the meeting. She added that when they get together to review a fall the team discusses npi, and diversional activities and that moving forward will document the discussion. On 7/12/24 at 10:49 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #227's fall investigations did not have a conclusion for the root cause or IDT meeting documented and that the last two falls did not have an additional npi intervention added and that both interventions were a psych consult. On 7/15/24 at 12:00 PM, in the presence of the survey team and LNHA, the DON stated that a npi option was added to include a behavior monitoring order to reflect npi. The DON confirmed that there was not a npi added after the fall. 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; . c. The circumstances surrounding the accident or incident; (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106 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 unwitnessed fall on 9/16/23 at 01:20 AM. Subsequently, the resident had increased pain and limited mobility requiring transfer to the emergency roiagnom on [DATE] at 11:54 AM, with a diagnosis of acute fracture of the intertrochanteric portion of the left femur and acute fracture of the left pubic ring; b.) provide adequate pain management; c.) failed to report the injury 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; COVID-19, spinal stenosis, cerebral infarction (stroke), and unsteadiness on feet. Review of the nursing progress note (PN) dated 9/15/23 at 18:40 (6:40 PM), reflected that Resident #316 was admitted to the facility awake, verbally responsive, and denied pain or discomfort. Review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of resident care dated 9/21/23, reflected that Resident #316 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated that the resident was cognitively intact. The MDS also reflected that the resident ambulated once or twice during the assessment reference period and required extensive assistance with activities of daily living. Further review of the MDS reflected that the resident complained of pain frequently and had one fall since admission to the facility. A review of Resident #316's Comprehensive person-centered Care Plan (CP) indicated that the resident was at risk for pain or discomfort associated with the diagnosis of spinal stenosis (the spaces inside the bones of the spine get too small). The interventions included the following: -Administer pain medications (meds) as ordered -Monitor and record pain 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 pain or request for pain treatments. -Notify the physician if interventions were unsuccessful or if the current complaint is a significant change from the resident's past experience of pain. -Anticipate the resident's need for pain relief and respond immediately. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the electronic Medication Administration Record (eMAR) dated 9/15/23, indicated physician ordered pain assessment to be performed every shift, pain scale of 0 indicated no pain, pain scale of 1-3 indicated mild pain, pain scale of 4-6 indicated moderate pain, and pain scale of 7-10 indicated severe pain. Non-pharmacological interventions to be administered prior to prn meds: The following codes were to be documented on the eMAR: 1-repositioning, 2-ice, 3-food, 4-distraction, 5-toileting and 6-relaxation techniques. Review of the Order Summary Report (OSR) showed a physician order (PO) with a start date of 9/16/23, for Physical Therapy (PT) evaluation and treat for 6x/wk (6 times/week) x 12 weeks. Further review of the OSR revealed a PO dated 9/15/23, for Acetaminophen (Tylenol) 325 milligrams (mg) to give two tablets (tabs) [total of 650 mg] to be administered every 6 (six) hours prn for mild pain. The PN dated 9/16/23 at 01:20 AM, indicated that around 12:00 AM, the Registered Nurse (RN) was called to Resident #316's room by the Certified Nursing Assistant (CNA). The resident was observed sitting on the floor next to the bed. The resident stated that they were going to the bathroom, lost their balance, and fell . The PN revealed that the RN conducted a body assessment, and the resident was able to move their upper and lower extremities without difficulty and denied pain. The surveyor reviewed the Incident and Accident investigation (IAI) dated 9/16/23, for an unwitnessed fall. The IAI indicated that the resident was to be monitored for nine shifts post-fall for the decrease in activities of daily living, pain, decrease in range of motion, and any change in the resident's appetite or vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions). There was no documented evidence on the report that the PT or occupational therapy (OT) department was notified that the resident had fallen. The PT note dated 9/17/23 at 12:14 PM, reflected that Resident #316 had complaints of pain in their left lower extremity and stated that their lower back hurt with movement of the left lower extremity. There was no documented evidence that the PT notified the nurse that the resident had complaints of pain, nor was there documentation that the PT was aware that the resident had fallen on 9/16/23. The nursing PN dated 9/17/23 at 14:07 (02:07 PM), indicated that the resident told the nurse that they fell on their buttocks the night before and the nurse notified the supervisor. (continued on next page)

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F 0689

Level of Harm - Actual harm

Residents Affected - Some

Note: The nursing home is disputing this citation.

A review of the PN dated 9/18/23 at 14:34 (02:34 PM), indicated that Resident #316 complained of pain on a verbal pain scale level 3 (three) which indicated mild pain. The nurse administered Tylenol 325 mg two tabs (tablets).

The PN dated 9/18/23 at 14:53 (02:53 PM), indicated that the resident complained of body pain not relieved by the Tylenol and the chart was to be reviewed by pain management for a pain management plan. There was no documented evidence that the nurse contacted the MD (medical doctor) regarding the residents' complaints of pain that were not relieved by the Tylenol. Furthermore, there was no assessment conducted when the resident began complaining of pain.

Review of the Physical Therapy Assistant (PTA) note dated 9/18/23 at 6:26 PM, indicated that the resident's movement was extremely limited by pain in the left groin and the left thigh area. There was no documentation that the PT notified the nurse regarding the resident's complaints of pain, nor was there documentation that the PT was aware that the resident had previously fallen.

The surveyor reviewed the Certified Occupational Therapy Assistant (COTA) notes dated 9/19/23 at 12:57 PM, which indicated that Resident #316 reported 7-8 on the pain scale (severe pain). The resident refused to get out of bed or any bed mobility due to pain in the lower back and left lower leg. There was no documented evidence that the COTA notified the nurse that the resident had complaints of severe pain and there was no documentation that the COTA was aware that the resident had fallen on 9/16/23.

According to the eMAR, the resident complained of pain on 9/19/23 on the 3-11 PM shift. The nurse documented on the eMAR that the resident complained of pain at a pain scale of 4 (four) indicating moderate pain. The documentation showed that the resident was not provided with non-pharmacological interventions, nor was the resident offered a prn pain med. The eMAR reflected that the resident was not provided with prn Tylenol for mild pain.

A review of the PN dated 9/19/23 at 14:56 (02:56 PM), indicated that the resident complained of full body pain that was not relieved by Tylenol and the MD was aware. There were no new PO and there was no documentation that the resident was reassessed for post-fall injury due to increased complaints of pain.

The PTA note dated 9/19/23 at 5:56 PM, indicated that the resident continued to loudly express pain with all movements and even with the anticipation of movement. The note indicated that the resident refused to move the left lower extremity due to pain. There was no documented evidence that the PT notified the nurse regarding the residents' complaints, nor was there documentation that the PT was aware that the resident had previously fallen.

According to the eMAR dated 9/20/23 on the 3-11 PM shift, the resident had complaints of pain at a pain scale of 6 which indicated moderate pain, and was offered non-pharmacological interventions included repositioning, food, and distraction to help relieve that pain. There was no documented evidence that pain med was provided. The PN dated 9/20/23 at 17:36 (5:36 PM), indicated that the resident had groin pain not relieved by pain management and was ordered stat (immediate) bilateral hip x-rays.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	A review of the PTA notes dated 9/20/23 at 5:54 PM indicated that Resident #316 continued to report pain in the left lower extremity. The note also revealed that it took 2 (two) staff with maximum assist if the resident allowed them to touch the resident. The note did not contain any information that the PT informed the nurse about the resident's complaints of pain. There was also no documentation that the PT was aware that the resident had previously fallen, and x-rays of the bilateral hips were ordered. The PN dated 9/20/23 at 18:24 (6:24 PM) revealed that the resident was unable to turn on their back due to pain and was not able to have the x-ray completed. The PN indicated that the MD and family were aware. No further MD orders or assessments were documented, and the resident was not provided with any additional prn pain meds when they continued to complain of pain. The PN dated 9/20/23 at 10:56 AM, indicated that the rehabilitation physician (Physiatrist) examined Resident #316 and documented that the resident refused to get out of bed (OOB) or perform any bed mobility due to pain in their lower back and left lower extremity. There was no documentation within the note that indicated that the MD was aware that the resident had fallen on 9/16/23. There was also no documented evidence that the physician was aware that the resident could not have the bilateral hip x-rays performed due to increased complaints of pain not relieved by Tylenol, and Lidocaine patch. There were also no additional pain meds ordered at this time and there were no interventions or treatments ordered for the resident. Review of the eMAR dated 9/21/23, indicated that the Resident complained of pain at a level of 6 which indicated moderate pain on 7am-3pm (day shift), 3pm-11pm (evening shift) and 11 am-7am (night shift). The day shift and evening shift provided non-pharmacological pain interventions however, the night shift did not provide any pain management intervention. At no time, on all shifts, did the resident receive any prn Tylenol. On 9/21/23 at 14:56 (02:56 PM), the nurse documented that the resident had complaints of full body pain not relieved by prn Tylenol. The note also indicated that the MD was aware. There were no new POs obtained for alternate pain management. The PTA note dated 9/21/23 at 4:28 PM, indicated that the resident had complaints of pain in the groin area when the PTA tried to move the left hip. There was no documented evidence that the PTA notified the nurse regarding the residents' complaints of pain. The Physician's PN dated 9/22/2023 at 12:13 PM, indicated that the Nurse Practitioner (NP) examined Resident #316. The NP documented that the resident was lying in bed and had complaints of body pains on and off. There was no documented evidence that the NP was aware that the resident had a fall on 9/16/23, or that the resident did not have bilateral hip x-rays completed due to pain. Review of the eMAR dated 9/25/23, for the Dayshift indicated that Resident #316 had complaints of severe pain at a level 7 and was provided with non-pharmacological interventions such as food, distraction, and relaxation. There was no documented evidence that the MD was notified of the resident's severe pain. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Further review of the PN, indicated a late entry note dated 9/25/23 at 13:03 (01:03 PM) from the Social Worker that the MD was in to see the resident that morning that the resident agreed to take the med Tramadol and that the resident did not want to be touched because of pain. The note also indicated that the resident had an active range of motion to the ankle (did not specify which one) but would not move their upper leg. The PTA note dated 9/25/23 at 5:39 PM, indicated that the resident continued to complain of pain in the left groin and the left knee. There was no documented evidence that the PTA notified the nurse regarding the resident's continued complaints of pain. According to the eMAR, the resident had a new PO dated 9/26/23 for Tramadol HCL (hydrochloride) 50 mg one tab once a day for pain. The resident did not receive a PO for the Tramadol HCL (a controlled med that can treat moderate to severe pain) 50 mg, until 10 days after resident fell and seven days after the resident had complained moderate to severe pain. According to the PTA notes dated 9/26/23, 9/27/23, 9/28/23, 9/29/23, and 9/30/23, the resident continued to receive PT despite resident's complaint of pain. A review of the PO dated 9/20/23, revealed an order for bilateral hip x-ray stat (immediately). A review of the radiology report showed that the test for bilateral hips with pelvis two views was done on 9/29/23, and was reported to the facility on [DATE], with the impression of acute femur fracture. Review of the PN dated 9/30/2023 at 11:54 AM, indicated that the resident had an x-ray and the results reflected that the resident had an acute fracture of the intertrochanteric portion of the left femur (bony protrusions on the femur (thighbone)) and acute fracture of the left pubic ring (a ring of bones located at the lower end of the trunk - between the spine and the legs). The MD was notified, and the resident was sent to the hospital emergency room for evaluation. On 7/09/24 at 11:38 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who explained that when a resident complained of pain, the resident's pain level needed to be documented and the pain med was to be administered as ordered by the MD. She stated that the nurse was responsible to document the location of the pain if the resident had pain with range of motion (ROM) and the resident's facial expression. She stated that if the pain was not relieved by the current pain med, the MD should be notified and that something different should be ordered to manage the resident's pain. She stated that if the resident still complained of pain and had limited ROM after getting the pain med changed, the MD and family should be notified, and the resident should be sent out to the hospital for evaluation. On that same date and time, the LPN reviewed Resident #316'2 eMAR and stated that when the resident had complained of pain above the pain scale of mild (1-3) and that the Tylenol was not effective in managing the resident's pain then the MD should have been notified so that they could get the appropriate pain med for moderate pain and severe pain. The LPN reviewed Resident #316's medical record in the presence of the surveyor and stated that if the resident refused to have an x-ray due to pain, the resident should have been sent to the hospital or evaluation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 7/10/24 at 9:15 AM, the surveyor interviewed the Director of Nursing (DON) who stated that she had been employed by the facility since 2020. The DON explained that the pain scale that the facility used was the numerical scale 0 no pain, scale 1-3 mild pain, scale 4-6 moderate pain, scale 7-10 severe pain. The DON stated that if Resident #316's pain was higher than a 3 level per indication of the Tylenol order then the staff should have notified the MD for a possible change in pain med. On that same date and time, the DON reviewed the PN and stated that the staff was monitoring the resident's pain and notified the MD on 9/20/23, 9/21/23, 9/22/23, 9/25/23. She stated that she could not speak as to why a different pain med was ordered or why the resident was not sent to the hospital after the resident refused to have the x-ray due to pain. She then stated that she could not speak to how the MDs conducted their decision-making. At that same time, the DON reviewed the IAI that was conducted after Resident #316 fell on [DATE], and stated that she did include factors that contributed to the resident's fall. The DON stated that she did not complete a summary or conclusion related to the fall and that was something she did not normally do. The DON stated that she did not know that if a fracture sustained during a fall had to be reported to the NJDOH. The DON stated that the facility followed the PO and felt that they followed protocol related to Resident #316 pain. Furthermore, the DON stated that the resident's fall was discussed with the nursing staff at the time of the fall, and then it was discussed with the supervisors on the coming shift. She explained that the Interdisciplinary Team (IDT) team, which consisted of the DON, Administrator, unit managers, assistant DON, Director of Rehabilitation, and Social Worker, meet every day at morning meetings except weekends. She stated that if the resident fell on the weekend, then it was communicated to the DON by the supervisor. She stated that she was not sure why it was not determined earlier that the resident's increase in pain was attributed to the fall that occurred on 9/16/23, and was not sure why the resident pain med was not effective in managing pain or why the resident was not sent to the hospital after refusing to have the x-ray due to pain. On 7/10/24 at 10:05 AM, the surveyor interviewed the Director of Rehabilitation (DOR) who stated that she had been employed in the facility for eight years. She stated that the treating PT and PTA that treated Resident #316 from 9/17/23-9/30/23 were no longer employed in the facility. The DOR explained that the PT evaluation was done prior to the fall on 09/16/23, OT evaluation was conducted on 9/16/23, after the resident fell . The DOR reviewed the documentation from both the COTA and PTA and confirmed that the therapist had documented that the resident was complaining of pain. The DOR continued to review the PT and OT notes and confirmed that OT documented that she notified the nursing staff on 9/29/23, regarding the resident complaints of pain and that nursing was going to get an x-ray. The DOR could not find any additional documentation during therapy sessions that the OT or PTA notified the nursing staff that the resident continued to have complaints of pain and was refusing to be touched due to the pain. On that same date and time, the DOR stated that the evaluating and treating therapist did not document that they were aware that the resident had fallen on 9/16/23. The DOR further stated that she could not remember that far back, however if it was not documented that the resident had a fall prior to rehabilitation treatment then she could not speak to why the staff did not document that they were aware of the resident's fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 7/10/24 at 10:26 AM, the surveyor interviewed the COTA who confirmed that she documented on 9/23/23 that she provided OT services to Resident #316. The COTA stated that the resident refused to reposition secondary to pain. The COTA 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 CNA and nurse regarding the resident's complaints of pain and refusal of OT services. On 7/10/24 at 10:45 AM, the surveyor interviewed the NP who stated that pain management was usually done by the physiatrist, however if Resident #316 was admitted with the diagnoses of spinal stenosis and chronic lower back pain the use of Tylenol and Lidoderm patches would have been sufficient pain treatment for that type of condition. The NP stated that he could not remember if he was notified that the resident had fallen or that the resident had increased complaints of pain not relieved by the Tylenol or the Lidoderm patches. At that time, the NP reviewed the resident's pain management and stated, It does look bad. If the resident told him he would have ordered additional pain management or x-rays. He stated that he did not remember if the nurses reported to him that the resident refused an x-ray that was ordered and stated that it should have been followed up on. He stated that would have to review his notes and get back to the surveyor. On 7/10/24 at 11:12 AM, the surveyor interviewed the facility's Physiatrist (physician of rehabilitation and pain management) who stated that she could not recall if she was told by therapy or the nursing staff that the resident had fallen on 9/16/23. 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 had fallen. She stated that the therapist would let her know that a resident had fallen and was having increased pain. The Physiatrist further stated that Probably that the resident had pain from spinal stenosis and left-sided weakness from a stroke. She stated that she did not order any X-rays while the resident was a patient. She stated that she was not in the facility for five days a week, however, when she had come in the 9/25/24, she had ordered the resident Tramadol for pain. 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 Licensed Nursing Home Administrator (LNHA) and DON. The surveyor notified the facility management of the above findings. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator 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 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: (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	-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). 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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0695

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe and appropriate respiratory care for a resident when needed.

48423

REPEAT DEFICIENCY

Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a.) administer oxygen therapy according to the physician's order, b.) ensure respiratory tubing, cannula, and masks were stored properly. This deficient practice was identified for two (2) of two (2) residents (Residents #111 and #466) reviewed for respiratory care 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.

1. During initial tour on 7/08/2024 at 10:10 AM, the surveyor observed Resident #111 sitting in the wheelchair in their room. The resident showed their unbagged nebulizer (neb) treatment mask with foggy appearance, on the bed dated 5/20 with a black marker.

According to the Admission Record (AR, an admission summary), Resident #111 was admitted to the facility with acute kidney failure, unspecified (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days), retention (failure to eliminate a substance from the body) of urine, unspecified, and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) without complications.

The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/16/24, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact.

A review of the active Physician's Orders (PO) revealed the following orders:

Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (milligrams/milliliters) (Ipratropium-Albuterol) 3 ml inhale orally every 6 hours as needed (PRN) for wheezing with a start date of 3/21/2024.

(continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Budesonide Inhalation Suspension 0.25 MG/2ML (Budesonide (Inhalation)) 2 ml inhale orally every 12 hours for asthma rinse mouth after with a start date of 3/29/2024. Further review of the above PO showed that there were no orders pertaining to changing of respiratory equipment such as neb treatment mask. The above PO was transcribed to the July 2024 electronic Medication Administration Record (eMAR) for Budesonide (Inhalation) 2 ml inhale orally every 12 hours for asthma rinse mouth after and the signed by nurses every shift as administered. A review of the PO did not reflect an order to change the neb treatment mask. The electronic Treatment Administration Record (eTAR) did not reflect an order to change the nebulizer treatment mask. During an interview with the surveyor on 7/12/24 at 11:25 PM, the Licensed Practical Nurse/Unit Manager (LPN/UM) stated that the oxygen (O2) tubing and the neb mask should be changed weekly. They (the night shift nurses) date and put their initials on it and changing the O2 tubing and neb mask weekly and the PO should be reflected in the eTAR. The LPN/UM acknowledged that it was bad that the mask was there for two months, and it can cause respiratory infection. The LPN/UM further stated the mask should be wiped off and placed back in the bag after use. On 7/12/24 at 12:42 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The IP/RN stated that the O2 tubing and the neb mask gets changed weekly, and That is our policy. The IP/RN further stated that there was a standing order for changing the O2 tubing and the neb treatment mask and they (the nurses) document in the eTAR. The IP/RN acknowledged that the mask should've not been there, and the bacteria builds up due to the moisture and there is a risk for infection control. On 7/15/24 at 12:00 PM, the survey team met with Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above findings. The DON stated that the neb mask should be changed weekly or as needed for infection control. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and Regional Administrator for an Exit Conference. The facility did not provide additional information and did not refute the findings. 38327 2. On 7/08/24 at 11:34 AM, the surveyor observed Resident #466 lying on the bed. There was an O2 concentrator (a medical device that separates nitrogen from the air around for residents to breathe up to 95% pure O2) at the bedside with O2 nasal cannula (N/C, is a device that delivers extra O2 through a tube and into the nose) directly on top of the O2 concentrator and was not stored in a bag. The O2 was not in use. The resident was stable and not in distress. On 7/10/24 at 9:12 AM, the surveyor observed the resident inside their room with a Physical Therapist (PT) at the bedside performing therapy. The resident was not on continuous O2 at this time. The resident was not in distress. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the electronic medical records (eMR) of Resident #466 and showed the following: The AR reflected that the resident was admitted to the facility with diagnoses that included a displaced fracture (broken) of the base of the neck of the left femur (thigh bone) sequela, end-stage renal (kidney) disease, dependence on renal dialysis (a type of treatment that helps the body remove extra fluid and waste products from blood when the kidneys are not able to), and chronic obstructive pulmonary disease unspecified (COPD, a group of lung diseases that block airflow and make it difficult to breathe). A review of the Comprehensive MDS (CMDS) with an assessment reference date (ARD) of 7/05/24 revealed in Section C Cognitive Patterns a BIMS score of 13 which reflected that the resident was cognitively intact. The CMDS also revealed that the resident was on O2 therapy as respiratory treatment while a resident in the facility. The July 2024 Order Summary Report (OSR) revealed a PO dated 6/28/24 for O2 via NC at 2L (two liters) continuous every shift for SOB (shortness of breath). The above order for O2 was transcribed into the July 2024 electronic Treatment Administration Record (eTAR) and was signed by nurses as administered from 7/01/24 through 7/11/24. A review of the personalized care plan (CP) showed that the resident had focused on CP that was initiated on 6/28/24 for has/at risk for respiratory impairment related to. The goal was blank. The interventions listed were initiated also on 6/2824 for O2 at (specify rate and method of delivery). 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 respiratory care on how to store the O2 cannula and supplies when not in use. On 7/12/24 at 7:46 AM, the surveyor and the Assistant Director of Nursing (ADON) went inside the resident's room, both observed the resident laying on the bed with O2 not in use and the O2 concentrator at the right side of the bed with a NC on top of the concentrator not stored in a bag. The ADON checked the NC with wrapped white tape and stated to the surveyor that the handwritten information on 7/11/24 at 6 AM was the date and time it was changed. Afterward, both the surveyor and the ADON walked outside the resident's room and went to the nursing station. The surveyor asked the ADON about the above observation of the NC and O2. The surveyor also notified the ADON of the above observations of the NC not properly stored [7/08/24 and 7/10/24] and the O2 was not in use when the nurses signed the eTAR that it was administered. The ADON 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 Licensed Practical Nurse (LPN), the assigned nurse regarding the resident's O2. The LPN informed the surveyor that when she came in today at 7 AM, the resident's O2 was not in use and the resident was not in distress. The LPN was unable to state if she observed at that time if the NC was in a bag. She had no further comment when the surveyor asked the nurse why the resident had no O2 in use when the PO was O2 continuous. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/12/24 at 10:27 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns regarding the resident's PO for O2 was not followed and improper storage of NC. A review of the facility's Oxygen Administration Policy with a reviewed/revised date of 01/2024 that was provided by the LNHA 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 LNHA and DON. The DON stated that the physician was notified of the surveyor's concern and the facility received a new PO to change the order for continuous O2 to PRN (as needed) O2. The DON further stated that the nurses should follow PO for O2 and that NC should be properly stored inside a bag when not in use. NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 39885 Based on interview and record review it was determined that the facility failed to ensure that a.) the residents' Attending Physician 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 Attending Physician visited and documented monthly visits or alternately visited every other month when the Advanced Practice Nurse 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 Attending Physician (AP) did not document any visit for March, April, May or June 2024. The Advanced Practice Nurse (APN), covering for the AP, documented an April and June 2024 monthly visit. There was not a documented AP visit for Resident #18 for the last four months and there was no visit by the APN or AP for May. 2. On 7/10/24 at 12:08 PM, the surveyor reviewed Resident #80's EMR which revealed that the resident's AP physician did not document any visit for March, April, May or June 2024. The APN, covering for the AP, documented only documented one visit which was dated 3/30/24. There was not a documented AP visit for Resident #80 for the last four months and there was no visit by the APN or AP for March, April or June. 3. On 7/09/24 at 11:03 AM, the surveyor reviewed Resident #227's EMR which revealed that the resident's AP physician did not document any visit for April, May or June 2024. The APN, covering for the AP, documented only one visit which was dated 5/26/24. There was not a documented AP visit for Resident #227 for the last three months and there was no visit by the APN or AP for April or June. 4. On 7/12/24 at 10:42 AM, the surveyor reviewed Resident #257's EMR which revealed that the resident's AP physician did not document any visit for May or June 2024. The APN, covering for the AP, documented the visits for May and June 2024. There was not a documented AP visit for Resident #257 for the last two months. On 7/11/24 at 12:08 PM, the surveyor interviewed the Unit Manager of 1A (UM1A) regarding the AP visits. The UM1A stated that the AP visited the residents once a month and that the APN would come visit if the resident needed something sooner and that the visit was documented in the electronic medical record. On 7/12/24 at 10:32 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concerns that the residents did not have an AP visit and that some months did not have an AP or APN monthly visit. On 7/15/24 at 11:55 AM, in the presence of the survey team and DON, the LNHA stated that the AP provided notes. The surveyor asked the LNHA to confirm what date the AP visited. The LNHA confirmed that the AP visited on 7/14/24. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility did not provide any additional information. 38327 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 with diagnoses that included a displaced fracture (broken) of the base of the neck of the left femur (thigh bone) sequela, end-stage renal (kidney) disease, dependence on renal dialysis (a type of treatment that helps the body remove extra fluid and waste products from blood when the kidneys are not able to), and chronic obstructive pulmonary disease unspecified (COPD, a group of lung diseases that block airflow and make it difficult to breathe). The Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 7/05/24 revealed in Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 13 out of 15 which reflected that the resident was cognitively intact. A review of the monthly PO revealed the AP and the APN had not hand-signed or electronically signed monthly orders for June 2024 and July 2024. Further review of the EMR revealed that the resident's AP did not document any visits in June and July 2024. The AP did not document a History and Physical (H&P) and the succeeding monthly visits for June and July 2024. On 7/10/24 at 11:41 AM, the surveyor interviewed and asked the Registered Nurse (RN) where the AP signed orders and how the nurse knew that the AP signed the orders. The RN stated that she was unsure how the AP signs orders or if the AP signs orders because she gets orders via phone call or enters the order of the AP in the EMR. The RN further stated that it would be the Assistant Director of Nursing (ADON) or the DON who could answer the question on where the AP signs orders. On that same date and time, the surveyor asked the RN where the AP documents the H&P and succeeding progress notes (PN) of the AP. The RN then checked the EMR. The RN acknowledged that she could not find the AP's H&P and PN. The RN stated that she would call the ADON and ask about it. On 7/10/24 at 12:20 PM, the surveyor interviewed the DON. The surveyor notified the DON of the above findings and concerns. The DON checked the resident's EMR and was unable to locate the AP's signed monthly orders, H&P, and PN. At that same time, the surveyor asked the DON what the facility's policy and practices on how many days should the AP and the APN sign the orders and how many days should the physician visit and documents for succeeding PN, the DON stated that she would get back to the surveyor. On 7/12/24 at 10:27 AM, the survey team met with the LNHA and DON. The surveyor notified the facility management of the above findings. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 LNHA and DON. The DON stated that the AP entered a late entry for H&P and PN. The DON further stated that the physician orders were signed after the surveyor's inquiry. NJAC 8.39-23.2(b)(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Post nurse staffing information every day. 48423 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. 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 Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) about the concern that the NHRSCR was not posted daily. On 7/15/24 at 01:30 PM, the LNHA informed the surveyor that the Assistant Administrator 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 LNHA, DON, Chief Nursing Officer, Corporate Compliance Officer, and the Regional Administrator. The facility management did not provide an additional information and did not refute the findings. NJAC 8:39-41.2

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49078 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 medication (med) nurse assigned to the South Side of the 2A Unit (med RN) prepare and administer medications (meds) to an unsampled resident. The surveyor observed the med RN 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 med RN 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 med RN 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 med RN 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 med RN 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 med RN if the med card containing Xarelto should have been left on top of the med cart unattended. The med RN stated, no, it should have been locked inside the cart. On 7/10/24 at 9:25 AM, the surveyor interviewed the RN/Unit Manager (RN/UM) for Unit 2A. The surveyor asked the RN/UM if it was appropriate to leave meds unattended on top of the med cart. The RN/UM stated that it was not appropriate and that meds should be locked up. 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 Licensed Nursing Home Administrator (LNHA) 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 01/2024 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 01/2024 also reflected on line 16 the statement No meds are kept on top of the cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 LNHA and Director of Nursing and discussed the med storage concern. The LNHA acknowledged the incident. The facility did not provide any further pertinent information. NJAC 8:39-29.4(h)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46049 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 Food Service Director (FSD), the surveyor 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 FSD 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 FSD was asked about earrings observed being worn in the kitchen by DA #1 and DA#2. The FSD stated servsafe guidelines indicated it shouldn't be worn. The FSD did provide further verbal response on the policy for jewelry in the kitchen. The surveyor requested the facility's policy on kitchen staff attire. On 7/09/24 at 10:45 AM, the survey toured the kitchen in the presence of the FSD. The surveyor observed DA#3 who had hair on his chin which was exposed and not covered. The FSD stated DA #3 should have his facial hair covered with a beard restraint (cover) and instructed DA #3 to put on a beard cover. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/10/24 at 9:03 AM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) 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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 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 transmission-based precautions (TBP) to prevent the potential spread of infection for two (2) of two (2) residents (Residents #41 and #111) and not utilizing personal protective equipment (PPE) for a resident on contact precautions for two (2) of two (2) staff (Attending Physician and HK#2) reviewed for TBP, in accordance with the Center for Disease Control and Prevention (CDC) guidelines and facility's policy. 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 [ROOM NUMBER]. 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 [ROOM NUMBERS]. 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 [ROOM NUMBER]. HK#1 went inside room [ROOM NUMBER]'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 [ROOM NUMBER]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/08/24 at 11:48 AM, the surveyor notified Registered Nurse #1 (RN#1) of the above concern regarding HK#1. The RN stated that she would notify the Housekeeping Director about it. The RN 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 Licensed Nursing Home Administrator (LNHA) 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 3 D unit. The Concierge Staff (CS) 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 3 D nursing station. The surveyor notified the CNA of the above concerns regarding no hand hygiene provided to the residents in the dining area on 7/08/24 during lunch observation. The CNA 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 7/08/24 before and after lunch. On 7/10/24 at 9:06 AM, the surveyor interviewed RN#1. The RN 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 LNHA and Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns regarding HK#1 and dining observation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/24 at 12:41 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The surveyor notified the above concerns regarding HK#1 and dining observation. The IP/RN 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 LNHA revealed: 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 LNHA and DON. The LNHA stated that we in-service the staff in the 3 D unit and HK#1 about hand hygiene. 48423 3. During initial tour on 7/08/2024 at 10:10 AM, the surveyor observed an Enhanced Barrier Precaution (EBP; infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) 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 Contact Precaution (used for patients with infections that can be transmitted by direct or indirect contact) 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 Contact Precaution 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: According to the Admission Record (AR; an admission summary), Resident #111 was admitted to the facility with acute kidney failure, unspecified (a condition when an abrupt reduction in kidneys' ability to filter waste products occurs within a few hours or a few days), retention (failure to eliminate a substance from the body) of urine, unspecified, and type 2 diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) without complications. The Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, dated 5/16/24, reflected a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Order Summary Report (OSR), included a physician order (PO), dated 7/08/2024 at 15:00 (3:00 PM) which read, Contact Precaution r/t [related to] MRSA [methicillin-resistant staphylococcus aureus, a type of bacteria that is resistant to several antibiotics] in the urine (gown & gloves) every shift for Infection control until 7/14/2024 23:59 (11:59 PM). A review of a nursing progress note (PN) dated 7/07/2024 at 8:51 AM indicated Resident #111 had a positive result for MRSA infection and needed antibiotic treatment. On 7/12/24 at 11:19 AM, the surveyor conducted an interview with the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated she would contact the physician and IP/RN immediately once a resident had a new positive result for MRSA. The LPN/UM further stated a resident would be placed on contact precautions. Contact precaution isolation signage and a PPE bin would be placed at the door of the room. The LPN/UM further stated that it was important to place a contact precaution signage to prevent the spread of infection. On 7/15/24 at 11:01 AM, the surveyor conducted an interview with the IP/RN who explained that as soon as nursing staff found out that a resident had an infection, they would notify the IP/RN and if it was an infection that required isolation precautions, it would be implemented by nursing staff. The IP/RN stated that the PO for isolation precautions and a care plan would be entered in the EMR (Electronic Medical Record). A PPE bin and a contact isolation sign would be posted above the name plate at the resident's door. The IP/RN further explained that We do not need PO and nurses can initiate contact isolation. She stated that it was important to place contact precaution signage and PPE bin at the door to prevent the spread of MRSA. On 7/15/24 at 12:00 PM, the survey team met with LNHA and DON. The surveyor notified the facility management of the above findings. On 7/16/24 at 02:11 PM, the survey team met the LNHA, DON, Chief Nursing Officer (CNO), Corporate Compliance Officer (CCO), and Regional Administrator (RA) 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 Contact Precaution sign above the name plate of Resident #111 and Resident #91's 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) was on Contact Isolation. The surveyor reviewed the medical records for Resident #91 which revealed the following: The AR documented Resident #91 was admitted to the facility with gout (a painful type of arthritis that usually affects one joint at a time), chronic (continuing for a long time) embolism (is a blockage in one of the arteries of the body due to a blood clot that has broken off from another location in the body) and thrombosis (a blood clot) of other specified veins; and tooth fracture. A comprehensive MDS (CMDS) dated [DATE], reflected a BIMS score of 8 out of 15, which indicated that Resident #91 had moderate cognitive impairment. Further review of the MDS in Section G for functional status, indicated that Resident #91 was independent with toilet hygiene and toilet transfer. Section H for bladder and bowel, indicated that Resident #91 was always continent of bowel and bladder. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

A review of OSR and nurse progress notes revealed Resident #91 was not on contact precautions.

On 7/12/24 at 11:19 AM, the surveyor conducted an interview with the LPN/UM 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 contact isolation in the room. The LPN/UM confirmed Resident #111 was on isolation and their roommate, Resident #91 was not on isolation.

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 CNA stated Resident #111 had a foley catheter and she emptied their urine in the bathroom toilet of the resident's room. The CNA stated that Resident #91 was independent with bladder and bowel and was also using the same bathroom in the room.

On 7/15/24 at 11:01 AM, the surveyor conducted an interview with the IP/RN who stated that she had discussed with the Infectious Disease (ID) physician regarding Resident #91 who was not on contact precautions and Resident #111 who was on contact precautions for MRSA in the urine being in the same room. The IP/RN continued that the ID physician said it was okay for the residents to share a room as Resident #111 had a urinary catheter, would not be using the bathroom and was being treated with an antibiotic. The IP/RN stated that when the staff dumped the urine in the toilet, 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 LNHA and DON. 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 urine in the toilet, she flushed the toilet and did not wipe the toilet. The CNA further 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 LNHA, DON, CNO, CCO, and RA 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 Contact Precaution 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 Contact Precaution sign above the name plate was an infection sign and that a Gown 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 7/08/2024 at 15:00 (3:00 PM) which read, Contact Precaution r/t [related to] MRSA in the urine (gown & gloves) every shift for Infection control until 7/14/2024 23:59 (11:59 PM).

On 7/12/24 at 11:19 AM, the surveyor conducted an interview with the LPN/UM who acknowledged that Resident #111 was on contact precautions and staff were required to don (put on) gloves and gown before entering Resident #111's room.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/24 at 12:42 PM, the surveyor conducted an interview with the IP/RN who stated that any staff entering a contact precaution isolation room was required to don gown and gloves. The IP/RN 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 LNHA and DON. 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 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 LNHA, DON, CNO, CCO, and RA for an Exit Conference. The facility did not provide any additional information. 49078 6. On 7/12/24 at 12:18 PM the surveyor observed the Enteric Contact Isolation (an infection control intervention used to control diseases that can be transmitted through direct or indirect oral contact with infected feces or contaminated articles) 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 Enteric Contact Isolation signage 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 Registered Nurse/Unit Manager (RN/UM) who was present in the hallway to identify the individual. The RN/UM stated that he was the Attending Physician (AP) for Resident #41 and Resident #103 which resided in the same room. The surveyor did not observe the AP 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 AP perform any hand hygiene including hand washing prior to exiting the resident's room. The surveyor asked the RN/UM if the AP should follow the procedure for Enteric Contact Isolation. The RN/UM stated yes, he should have. The surveyor observed the RN/UM approach the AP and inform him of the observation and of the Enteric Contact Isolation signage. The surveyor asked the RN/UM the procedure for visitors who would want to enter a room with Enteric Contact Isolation. The RN/UM 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 IP/RN. The surveyor asked what the expectation was for all staff and providers when entering and leaving a room that was identified as Enteric Contact Isolation. The IP/RN 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 Enteric Contact Isolation. On 7/15/24 at 10:00 AM, the surveyor interviewed the LNHA. The surveyor asked the LNHA if physicians were expected to follow the same infection control practices and policies as the other staff. The LNHA stated, yes, they should and that they should be educated and informed of those policies and procedures for infection control. The facility provided no further information pertinent to this observation. 7. On 7/12/24 at 12:18 PM the surveyor observed the Enteric Contact Isolation signage 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 including but not limited to Multiple sclerosis (a disease that affects the central nervous system), paraplegia (a paralysis of the legs and lower body), and anemia (low red blood cell count). The CMDS dated [DATE], reflected a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. Section H of the MDS, Bowel and Bladder, reflected that Resident #41 had an indwelling suprapubic catheter (a tube inserted through the abdomen to the bladder to drain urine into an external bag) and was incontinent of bowel. The resident's OSR for other orders indicated a PO dated 7/10/24 with an end date of 7/15/24 for TBP: Enteric Contact Precautions C-DIFF (gown and gloves). The resident's recent laboratory results revealed a positive result for Clostridium Difficile (C-Diff) (an infection of the lower bowel usually resulting in loose stools) dated 6/20/24. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician's Progress notes revealed a Physician encounter note dated 7/12/24 by the resident's AP. The note included a diagnosis of C. Difficile colitis. Further review of Resident #41's medical record revealed the isolation policy was in effect for Resident #41 during the treatment of an infection 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 [DATE] revealed that Section H reflects the resident as always continent of bowel. Further review of Resident #103's medical record revealed the resident did not have an infection that required isolation. On 7/15/24 at 10:07 AM, the surveyor interviewed CNA#3 that provides care for both Resident #41 and Resident #103. The CNA stated that Resident #41 requires total care, was incontinent of bowel and has a catheter with a bag that gets emptied regularly. The CNA stated that Resident #103 also has a catheter and bag and was sometimes incontinent of bowel when they can not get to the bathroom in time. The surveyor asked the CNA if Resident #103 uses the toilet located in the room. The CNA responded, yes, sometimes. The surveyor asked the CNA if both catheter bags are emptied in the toilet located in the resident's room. The CNA stated, yes. On 7/15/24 at 10:43 AM, the surveyor interviewed the IP/RN in the presence of the survey team. The IP/RN was asked why a resident who required isolation procedures in the same room as a resident who did not. The IP/RN stated that as of 7/15/24, Resident #41 was considered no longer positive, will be taken off isolation and a terminal clean of the room will be done. Resident #41's roommate, Resident #103 was offered to change to another room but refused, and Resident #103 was informed of the risks of infection. The IP/RN stated she was not aware that Resident #103 used the toilet and that she thought the resident was incontinent of bowel all the time. The IP/RN could not state why a commode was not offered. She further acknowledged that if she knew that Resident #103 uses the toilet, she could have provided an alternative means of use of toilet which was the commode. 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. NJAC 8:39-19.4(a)(1)(2)(c)(m)(n), 27.1(a)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38327 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 7/10/24. The resident discussed the 1 A/B public toilet room safety railing was loose which Resident #83 had previously reported to the Housekeeping Director (HD) and the Licensed Nursing Home Administrator (LNHA) via email. The resident further stated that the 1 A/B 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) who had a cut on their foot and blood was all over the carpet of the chapel. The resident stated that he/she reported the blood in the carpet to the Maintenance Person (MP) who told the resident that they were not responsible for blood spills. Resident #83 further stated that since then the blood stained the carpet and no one cleaned it. On 7/15/24 at 10:44 AM, the surveyor with the LNHA went to the chapel and observed blood stains, and black stains #1, 2, and 3 on the chapel carpet floor. The surveyor notified the LNHA of the concern of Resident #83 about an incident a month ago regarding the blood stain and the LNHA stated that he would get back to the surveyor. The LNHA further stated that it should have been cleaned. On 7/15/24 at 10:55 AM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN). The IP/RN stated that when there was a blood spill on the floor, the facility uses the blood spill kit by nursing and then housekeeping will clean afterward. At that time, the surveyor with the IP/RN went inside the chapel and showed the blood stain on the carpet. Both the surveyor and the IP/RN observed the two housekeeping personnel cleaning the area where there was a blood stain. Both the housekeeping personnel informed the surveyor and the IP/RN 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 IP/RN also observed the six ceiling tiles with brownish discoloration which the IP/RN claimed was probably due to condensation. On 7/15/24 at 11:53 AM, the survey team met with LNHA and the Director of Nursing (DON). The surveyor notified the facility management of the above findings and concerns. On that same date and time, the LNHA provided a piece of paper with Resident #35's name on it and the date of the left foot incident that happened on 6/16/24 at the chapel. (continued on next page)

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	315303	A. Building 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

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/24 at 10:23 AM, the surveyor and the LNHA both went to the 1 A/B public toilet room and both observed the safety railings were loose when the LNHA attempted to shake it. The LNHA stated that he would call Maintenance immediately to fix it. On 7/16/24 at 12:32 PM, the survey team met with the LNHA, DON, and Chief Nursing Officer (CNO). The LNHA stated that the facility ordered new ceiling tiles for the chapel. 48423 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 wheelchair 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 with obesity, unspecified, osteoarthritis (a common joint condition where the cartilage, which cushions the ends of your bones, wears down over time) of knee, unspecified, osteoarthritis of hip, unspecified and dependence on wheelchair. The Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 5/16/24, Section C Cognitive Patterns revealed that Resident #32 had modified independence with decision making regarding tasks of daily life. At 11:50 AM, the surveyor conducted an interview with House Keeping staff (HKS), who looked at the floor and identified that it's (the floor) got to be clean. HKS further stated if the floor needs to be stripped, they contact the HD. HKS acknowledged that It's (the floor) got to be stripped and waxed. The HKS further stated that Maintenance does the painting, repairs, plumbing, fix TV and sinks. At 12:11 PM, the surveyor conducted an interview with Director of Maintenance (DoM) in unsampled Resident #32's room and DoM 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. DoM identified there was a leak more than a year ago. DoM stated, he fixes worse things first. At that same time, the surveyor and DoM toured the resident's bathroom. DoM was able to lift up the right front leg of the toilet railing. DoM 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 unsampled Resident #32's toilet railing and it was loose. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 12:00 PM, the survey team met with LNHA and DON. 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 LNHA, DON, CNO, Corporate Compliance Officer, and the Regional Administrator. The facility management did not provide additional information and did not refute the findings. NJAC 8:39-31.4 (a)(b)(f)