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	01/30/2026

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to implement their abuse policy by thoroughly investigating an allegation of staff-to-resident physical abuse to a cognitively intact resident (Resident # 194) who reported the abuse allegation to the Registered Nurse (RN #1) on 01/01/26. This deficient practice was identified for 1 of 5 residents (Resident # 194) reviewed for abuse. On 1/28/26 at 1:00 PM, the surveyor interviewed Resident # 194, who stated that during the 11 PM to 7 AM shift on 12/31/25, the resident was in the day room with Resident # 158 watching the ball drop before midnight. Resident # 194 stated they got into a physical altercation with the Licensed Practical Nurse (LPN #1), which included LPN #1 yelling and poking their finger in Resident # 194's face, and stomping on the resident's right foot. Resident # 194 stated that the next morning on 01/01/26, they reported what happened to the Registered Nurse (RN #1). The facility processed the resident's concern as a grievance allowing LPN #1 continue working having access to Resident # 194, as well as other residents without conducting a thorough investigation. The facility's failure to implement their abuse policy by thoroughly investigating all allegations of abuse placed Resident # 194, as well as all residents, at risk for abuse. This posed the likelihood of serious physical and emotional harm, or impairment, and resulted in an Immediate Jeopardy (IJ) situation. The IJ began 01/01/26, after Resident #194 made an allegation of staff-to-resident physical abuse. The facility was notified of the IJ on 01/28/26 at 11:15 PM. The facility submitted an acceptable Removal Plan (RP) on 01/30/26 at 3:14 PM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 01/30/26 at 8:21 PM. The evidence was as follows: Refer to F 600A review of the facility's policy titled Abuse Investigation and Reporting, dated revised 01/26, revealed .If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented. Upon conclusion of the investigation, the investigator will record the results of the investigation and provide the completed documentation to the Administrator. On 01/28/26 at 1:00 PM, the surveyor interviewed Resident # 194, who stated that during the 11 PM to 7 AM shift on 12/31/25, the resident was in the day room with Resident # 158 watching the ball drop before midnight. Resident # 194 went to the medication cart where Licensed Practical Nurse (LPN #1) was standing and requested medication for a headache. Resident # 194 stated that LPN #1 yelled at them and said, Don't you know not to bother me when I'm at the medication cart. Resident # 194 returned to the day room and forty minutes later LPN #1 went into the day room and handed Resident # 194 a cup with medication in it. Resident # 194 threw the medication over their shoulder and told LPN #1 it would be ineffective now since it took so long for it to be administered. Resident # 194 stated LPN #1 got down in the resident's face and started poking their finger in the resident's face, eye and forehead. Resident # 194 further stated that LPN #1 began yelling close enough that the resident felt the nurse's spit on their face and LPN #1 stomped on Resident # 194's right foot. Resident # 194 stated that the next morning they reported what happened to the Registered Nurse (RN #1). Resident # 194 further stated that LPN (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	#1 did it right in front of the cameras. Resident # 194 stated the Administrator in Training (AIT) and another head nurse came in and talked to Resident # 194 and apologized for what happened and told Resident # 194 that should not have happened and that they were going to review the video from the camera in the day room. Resident # 194 stated LPN #1 continued to work and gave medications to the residents during the 11 PM to 7 AM shift last night. Resident # 194 stated they did not like LPN #1 being their nurse, and the resident did not understand why the facility did not at least assign LPN #1 to another hall. Resident # 194 stated they did not trust LPN #1, and Resident # 194 didn't take their eyes off LPN #1. Resident #194 further stated they watched LPN #1 get medications out of the cart before the resident ingested them. Resident # 194 stated they no longer went into the day room to watch television with their fellow residents because it had bad memories for them now since the incident happened. A review of Resident # 194's Face Sheet, located in the electronic medical record (EMR) under the Profile tab, revealed the resident had a diagnosis of chronic obstructive pulmonary disease (COPD). A review of Resident # 194's quarterly Minimum Data Set (MDS), an assessment tool with an Assessment Reference Date (ARD) of 12/25/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. A review of the Facility Summary, signed and dated 01/02/26, by the Director of Nursing (DON) and provided by the facility, revealed that the facility received a grievance from an alert and oriented resident (Resident # 194) alleging that a nurse was not being nice and failed to administer requested medication. Resident # 194 reported feeling dismissed when asking for medication assistance. An investigation was initiated promptly in accordance with facility policy. Interviews were conducted with the involved nurse, staff present on the unit, and multiple alert and oriented residents who were in the immediate area at the time of the incident. A further review of the Facility Summary, revealed a typed unsigned statement dated 01/01/26, taken by Infection Preventionist (IP) from Resident #194 with no time, revealed Last night I felt a migraine starting so I went to ask [LPN #1] for my Topiramate [anticonvulsant medication]. [LPN #1] asked me to wait until they were done counting and to move away from the cart, so [LPN #1] doesn't make a mistake. I told [LPN #1] I needed it immediately otherwise it won't work. [LPN #1] said I needed to wait until they were finished. [Resident # 242] asked [LPN #1] for Tylenol and [LPN #1] told [Resident # 242] to wait also. I went back into the dayroom, me, [Resident #158] and [Resident # 242] were watching TV, we like to do that in the evening. [LPN #1] came in later and gave [Resident # 242] medicine and gave me my pill. I was upset and threw it over my shoulder. I called [LPN #1] some nasty names, even used the N word. I feel bad, I have never used that word before. [LPN #1] was telling me about how PRN [as needed] medicine is given and that it's not scheduled for an exact time. [LPN #1] bent down and was talking to me close to my face. I even picked up my hand in front of my face. [LPN #1] told me she has to find the pill and throw it away so nobody else can take it. I saw [LPN #1] find it on the floor and leave the dayroom. [LPN #1] came back later to clean up the table and went around my chair, bumping my foot. [LPN #1] left the room again and I stayed watching TV with [Resident # 158] and [Resident # 242]. A further review of the Facility Summary, revealed a typed unsigned statement dated 01/01/26, taken by the IP from Resident # 158, revealed [LPN #1] was counting medicine at the cart and [Resident # 194] went to [LPN #1] asking for medicine for a headache. The nurse asked [Resident # 194] to wait a few minutes until [LPN #1] finishes so [LPN #1] doesn't make a mistake. [Resident #194] came back into the dayroom and was upset. [Resident # 242] asked the nurse for Tylenol, [LPN #1] asked [Resident # 242] also to wait a few minutes until [LPN #1] finishes counting. I tried to calm [Resident #194] down and told [Resident # 194] why are you making such a fuss to wait a few minutes, but [Resident # 194] didn't want to listen to me. [Resident # 194] told me I'm gonna throw it away if [LPN #1] brings it to me now. A few minutes later the nurse came in with medicine for [Resident # 242] and [Resident # 194] and some water. [Resident # 242] took [theirs] and [Resident # 194] threw [theirs] over their shoulder and started saying rude things to the nurse, calling her racial slurs. The nurse tried to explain to [Resident # 194] that their medicine is not (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	scheduled for a specific time and it's dangerous to throw pills on the floor that other residents can find, but [Resident # 194] didn't want to listen. I saw the nurse look on the floor for the medicine, found it, and went to throw it away. She came back later to collect the dirty cups from the table. The three of us stayed watching TV, we wanted to watch the ball drop. A review of the Facility Summary, included a typed unsigned statement dated 01/01/26, taken by the IP from RN #1 which revealed, [RN #1] came to let me know that [Resident #194] stated they were upset about what happened last night with [LPN #1] and [Resident # 194] didn't get their migraine medicine. [RN #1] said [Resident # 194] told [RN #1] the nurse bumped [Resident # 194's] foot when walking by their wheelchair and that [LPN #1] was also talking to very close to [Resident # 194's] face. I told [Resident # 194] I will let the DON know immediately and I will go speak with [Resident #194]. I told [RN #1] to complete a full skin assessment to make sure there is no injury. On 1/28/26 at 6:06 PM, the surveyor interviewed RN #1, who stated they entered Resident # 194's room to pass medications the morning of 01/01/26, between 9 AM and 10 AM, and Resident # 194 told her they had an altercation with LPN #1. RN #1 stated that Resident # 194 reported that LPN #1 was yelling and said some nasty things to them and stomped on their foot, poking the resident in the forehead which made Resident # 194 call LPN #1 a racial slur. RN #1 stated she was told that they were going to review the cameras because they had issues with Resident # 194 making false allegations in the past. RN #1 stated she never heard the outcome of the investigation and was never interviewed or asked to write a statement. RN #1 stated she just assumed they completed their investigation since [LPN #1] was still working at the facility. RN #1 stated she's been waiting for someone to speak to her about the allegation and that she would be happy to write a statement. On 1/28/26 at 4:15 PM, the surveyor interviewed Resident # 158, who confirmed Resident # 194's allegation of staff-to-resident physical altercation. Resident # 158 stated that LPN #1 started yelling at Resident # 194 and poked her finger in Resident # 194's face. Resident # 158 stated they were unable to see if the nurse's finger actually touched the resident's skin. Resident # 158 stated that Resident # 194 called LPN #1 a derogatory name and LPN #1 said to Resident # 194 guess what? You're not getting your 7 AM medication from this [derogatory name]. Resident # 158 further stated that LPN #1 stomped on Resident # 194's foot and that Resident # 194 was only wearing flip flops. Resident # 158 stated that LPN #2 and RN #2 came and asked about what happened and that Resident # 158 told them everything they observed. On 01/28/26 at 6:55 PM, the surveyor interviewed the DON, who stated their process when an allegation was made, they interviewed residents or staff who may have witnessed the incident or were in the area where the incident occurred. The DON stated they have a conversation with their regional person to determine if it's a reportable or a grievance, but they did not report all allegations. The DON stated if they did report an allegation of staff-to-resident abuse, the staff member would be removed from the building and not allowed to return until the investigation was completed. The DON confirmed they did not report the allegation that Resident # 194 made. The DON stated they determined it was a grievance and not something that needed to be reported. The DON stated they interviewed other residents and staff who were present at the time the incident occurred, but she did not know which staff or residents were interviewed and was unable to provide any documentation of these interviews and stated they would be provided the next day. The DON stated they were in a locked cabinet that nobody currently in the building had access to and was unable to state why the interviews were not in the folder with the grievance form that was completed related to the allegation. During a follow-up interview on 01/29/26 at 12:10 PM, Resident #194 re-told the same allegations that they initially reported on 01/28/26, and denied reporting the information that was written in the above statement for them by the IP. On 01/29/26 at 4:10 PM, the surveyor interviewed the Licensed Nursing Administrator Home (LNHA), who stated that the facility met quarterly for quality assurance and performance improvement (QAPI). The LNHA stated their last meeting was 12/02/25, for the 3rd quarter, and they had not identified any system failures. The LNHA stated he was the point person for all allegations of abuse and was the facility's abuse coordinator. The LNHA stated any allegations of (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	abuse were discussed by the team, and they would collect statements and do their due diligence to find out what happened. The LNHA stated that he honestly felt they came to the right conclusion. The LNHA stated looking back maybe they should have suspended LPN #1, but they still did not feel the allegation warranted that response. On 01/30/26 at 8:17 AM, the surveyor interviewed the IP, who stated that on 01/01/26, she was the only nursing supervisor working since it was a holiday. The IP stated they were made aware of the staff to resident altercation by RN #1 and that Resident # 194 was upset about an incident that occurred during the night shift with LPN #1. The IP stated she was asked by the DON to get statements from the staff and residents who were working or in the area when the incident occurred. The IP stated she had never been trained on investigating, and this was the first time she completed one. The IP stated she did not allow the residents or staff that she spoke with to write their statements, and she documented what they told her. The IP stated the statements were not provided to the DON or the LNHA after it was completed so they would not have copies of them, so they were unable to provide them when they were requested the night before. The IP stated she put them in her filing cabinet and forgot about them. The facility submitted an acceptable Removal Plan (RP) on 01/30/26 at 3:14 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the immediacy including; on 01/28/26, the staff member [LPN #1] identified in the allegation was immediately removed from the schedule and an investigation was initiated in accordance with facility policy. On 01/28/26, Resident # 194 was assessed by nursing staff for any signs of injury or distress, and was provided with a trauma screen, emotional support, and a psychiatric consultation on 01/29/26. All alert and oriented residents who received care from LPN #1 between 01/01/26 through 01/28/26, will be interviewed beginning on 01/30/26, to assess for any concerns and confirm resident safety. The facility's Abuse Investigation Policy was revised on 01/29/26, by the DON and the LNHA to clarify that any allegation regardless of severity level, triggers an immediate investigation, and facility wide training on Investigation of Abuse was initiated on 01/28/26, by the DON. The survey team verified the implementation of the RP on-site during the continuation of the survey on 01/30/26 at 8:21 PM. NJAC 8:39-4.1(a)(5)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, interview, and policy review, it was determined that the facility failed to implement their abuse policy to ensure residents were protected from abuse including physical and verbal abuse. During the 11 PM to 7 AM shift on 12/31/25, the Licensed Practical Nurse (LPN #1) got into a witnessed physical altercation with Resident # 194, which included yelling and poking their finger in Resident # 194's face and stomping on the resident's right foot. The resident reported after the altercation, they did not trust LPN #1 and they had to watch LPN #1 get their medications out of the cart before Resident # 194 ingested them, and the resident stated they could no longer go to the day room to watch television with their fellow residents because it had bad memories. This deficient practice was identified for 1 of 5 residents (Resident # 194) reviewed for abuse, and was evidenced by the following:A review of the facility's policy titled Abuse Investigation and Reporting, dated revised 01/26, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management. Allegations of abuse/neglect will be reported to local, state, and federal agencies (as defined by current regulations). If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented. Upon conclusion of the investigation, the investigator will record the results of the investigation and provide the completed documentation to the Administrator. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than: two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury. A review of the facility's policy titled Abuse and Neglect-Clinical Protocol, date revised 01/26, revealed the definition of Abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. On 1/28/26 at 1:00 PM, the surveyor interviewed Resident # 194, who stated that during the 11 PM to 7 AM shift on 12/31/25, the resident was in the day room with Resident # 158 watching the ball drop before midnight. Resident # 194 went to the medication cart where Licensed Practical Nurse (LPN #1) was standing and requested medication for a headache. Resident # 194 stated that LPN #1 yelled at them and said, Don't you know not to bother me when I'm at the medication cart. Resident # 194 returned to the day room and forty minutes later LPN #1 went into the day room and handed Resident # 194 a cup with medication in it. Resident # 194 threw the medication over their shoulder and told LPN #1 it would be ineffective now since it took so long for it to be administered. Resident # 194 stated LPN #1 got down in the resident's face and started poking their finger in the resident's face, eye, and forehead. Resident # 194 further stated that LPN #1 began yelling close enough that the resident felt the nurse's spit on their face and LPN #1 stomped on Resident # 194's right foot. Resident # 194 stated that the next morning they reported what happened to the Registered Nurse (RN #1). Resident # 194 further stated that LPN #1 did it right in front of the cameras. Resident # 194 stated the Administrator in Training (AIT) and another head nurse came in and talked to Resident # 194 and apologized for what happened and told Resident # 194 that should not have happened and that they were going to review the video from the camera in the day room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	three of us stayed watching TV, we wanted to watch the ball drop. A review of the Facility Summary, included a typed unsigned statement dated 01/01/26, taken by the IP from RN #1 which revealed, [RN #1] came to let me know that [Resident #194] stated they were upset about what happened last night with [LPN #1] and [Resident # 194] didn't get their migraine medicine. [RN #1] said [Resident # 194] told [RN #1] the nurse bumped [Resident # 194's] foot when walking by their wheelchair and that {LPN #1] was also talking to very close to [Resident # 194's] face. I told [Resident # 194] I will let the DON know immediately and I will go speak with [Resident #194]. I told [RN #1] to complete a full skin assessment to make sure there is no injury. On 1/28/26 at 4:15 PM, the surveyor interviewed Resident # 158, who confirmed Resident # 194's allegation of staff-to-resident physical altercation. Resident # 158 stated that LPN #1 started yelling at Resident # 194 and poked their finger in Resident # 194's face. Resident # 158 stated they were unable to see if the nurse's finger actually touched the resident's skin. Resident # 158 stated that Resident # 194 called LPN #1 a derogatory name and LPN #1 said to Resident # 194, guess what? You're not getting your 7 AM medication from this [derogatory name]. Resident # 158 further stated that LPN #1 stomped on Resident # 194's foot and that Resident # 194 was only wearing flip flops. Resident # 158 stated that LPN #2 and RN #2 came and asked about what happened and that Resident # 158 told them everything they observed. On 1/28/26 at 6:06 PM, the surveyor interviewed RN #1, who stated they entered Resident # 194's room to pass medications the morning of 01/01/26, between 9 AM and 10 AM, when Resident # 194 told RN #1 that they had an altercation with LPN #1. RN #1 stated that Resident # 194 reported that LPN #1 was yelling and said some nasty things to them and stomped on their foot, poking the resident in the forehead which made Resident # 194 call LPN #1 a racial slur. On 01/28/26 at 6:55 PM, the surveyor interviewed the DON, who stated their process when an allegation was made, they interviewed residents or staff who may have witnessed the incident or were in the area where the incident occurred. The DON stated they have a conversation with their regional person to determine if it's a reportable or a grievance, but they did not report all allegations. The DON stated if they did report an allegation of staff-to-resident abuse, the staff member would be removed from the building and are not allowed to return until the investigation was completed. The DON confirmed they did not report the allegation that Resident # 194 made. The DON stated they determined it was a grievance and not something that needed to be reported. On 1/29/26 at 11:49 AM, the surveyor interviewed the Mental Health Professional (MH #1), who stated they spoke with Resident # 194 on 1/13/26, and that the resident reported that LPN #1 put their hands on them and stomped on their foot. During a follow-up interview on 01/29/26 at 12:10 PM, Resident #194 re-told the same allegations that they initially reported to the surveyor on 01/28/26, and denied reporting the information that was written in the above statement for them by the IP. On 01/30/26 at 8:17 AM, the surveyor interviewed the IP, who stated that on 01/01/26, they were the only nursing supervisor working since it was a holiday. The IP stated they were made aware of the staff-to-resident altercation by RN #1 and that Resident # 194 was upset about an incident that occurred during the night shift with LPN #1. The IP stated that Resident # 194 told them that they were upset that the resident did not get their migraine medication when the resident requested it from LPN #1 and that LPN #1 was counting medication and asked Resident # 194 to wait. The IP further stated that when the nurse came to give them their medication, the resident said it was too late and threw the medication and called LPN #1 racial slurs. Resident # 194 also told LPN #1 they did not know what they were doing. The IP further stated that Resident # 194 said that LPN #1 bent down to try to retrieve the medications and that LPN #1 was talking so close to Resident # 194 that the resident had to put their hand in between their face. The IP said that Resident # 194 also told them that LPN #1 bumped the resident's foot when the nurse went around the table to get the pill. The IP acknowledged that it was inappropriate for a staff member to be that close to a resident's face when speaking. The IP stated that it could be intimidating to someone. The IP further stated that they had not thought about it that way until now when it was put that way. The IP stated it was not said any different than how Resident # 194 reported it when it was first reported to the IP. On 01/29/26 at 4:10 (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who stated that the facility met quarterly for quality assurance and performance improvement (QAPI). The LNHA stated their last meeting was on12/02/25, for the 3rd quarter, and they had not identified any system failures. The LNHA stated he was the point person for all allegations of abuse and was the facility's abuse coordinator. The LNHA stated any allegations of abuse were discussed by the team, and they would collect statements and do their due diligence to find out what happened. The LNHA stated that he honestly felt they came to the right conclusion. The LNHA stated looking back maybe they should have suspended LPN #1, but they still did not feel the allegation warranted that response. NJAC 8:39-4.1(a)(5) NJAC 8:39-9.4(f) NJAC 8:39-13.4

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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. Based on observations, interviews, and facility policy review, the facility failed to ensure that food was not expired according to professional standards for food service safety in one of one kitchen. This failure had the potential to cause the spread of foodborne illness to all 256 census residents.Findings include:During initial observations of the kitchen on 01/27/26 beginning at 9:47 AM, the following was observed:-In the dry storage, three one-quart bottles of food dye displaying a manufactures expiration date of 03/27/25. The Director of Dietary (DOD) stated that those bottles should have been discarded.During an interview on 01/27/26 at 10:35 AM, the DOD stated that the three one-quart bottles were passed the use by date. The DOD stated that there was an audit of the food items completed to ensure no other food items were passed the use by date.During an interview on 01/28/26 at 9:45 AM the Registered Dietitian (RD) stated that the kitchen should not have had food items in stock that were beyond the use by date.Review of the facility's policy titled, Operation Manual-Dietary Services, dated 07/25, revealed that the policy did not address food storage policies and procedures. 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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interviews, record review, and review of pertinent facility documents, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure staff, as well as himself, implemented the facility's abuse policies and procedures to ensure resident safety and well-being by a.) protecting all residents from an alleged perpetrator pending a thorough investigation for an allegation of staff-to-resident physical abuse; and b.) thoroughly investigating an allegation of staff-to-resident physical abuse. This deficient practice was identified for 1 of 5 residents (Resident #194) reviewed for abuse, and was evidenced by the following: Refer F 600 and F 610 A review of the facility's Administrator Job Description, dated 12/2018, revealed the Administrator should lead and direct overall operations of the facility in accordance with customer needs, government regulations, and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objective. Monitor company identified Key Performance Indicators and addressed issues that affect performance of the facility. Responsible for the QA (Quality Assurance) program. Maintain a working knowledge of and confirm compliance with governmental regulations. A review of the facility's policy titled Abuse Investigation and Reporting, dated revised 01/26, revealed all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be thoroughly investigated by facility management. Allegations of abuse/neglect will be reported to local, state, and federal agencies (as defined by current regulations). If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented. Upon conclusion of the investigation, the investigator will record the results of the investigation and provide the completed documentation to the Administrator. An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than: two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or twenty-four (24) hours if the alleged violation does not involve abuse and has not resulted in serious bodily injury.ˆ On 01/28/26 at 1:00 PM, the surveyor interviewed Resident # 194, who stated that during the 11 PM to 7 AM shift on 12/31/25, the resident was in the day room with Resident # 158 watching the ball drop before midnight. Resident # 194 went to the medication cart where Licensed Practical Nurse (LPN #1) was standing and requested medication for a headache. Resident # 194 stated that LPN #1 yelled at them and said, Don't you know not to bother me when I'm at the medication cart. Resident # 194 returned to the day room and forty minutes later LPN #1 went into the day room and handed Resident # 194 a cup with medication in it. Resident # 194 threw the medication over their shoulder and told LPN #1 it would be ineffective now since it took so long for it to be administered. Resident # 194 stated LPN #1 got down in the resident's face and started poking their finger in the resident's face, eye, and forehead. Resident # 194 further stated that LPN #1 began yelling close enough that the resident felt the nurse's spit on their face and LPN #1 stomped on Resident # 194's right foot. Resident # 194 stated that the next morning they reported what happened to the Registered Nurse (RN #1). Resident # 194 further stated that LPN #1 did it right in front of the cameras. Resident # 194 stated the Administrator in Training (AIT) and another head nurse came in and talked to Resident # 194 and apologized for what happened and told Resident # 194 that should not have happened and that they were going to review the video from the camera in the day room. Resident # 194 stated LPN #1 continued to work and gave medications to the residents during the 11 PM to 7 AM shift last night. Resident # 194 stated they did not like LPN #1 being their nurse, and the resident did not understand why the facility did not at least assign LPN #1 to another hall. Resident # 194 stated they did not trust LPN #1, and Resident # 194 didn't take their eyes off LPN #1. Resident #194 further stated they (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	watched LPN #1 get medications out of the cart before the resident ingested them. Resident # 194 stated they no longer went into the day room to watch television with their fellow residents because it had bad memories for them now since the incident happened. On 01/28/26 at 4:15 PM, the surveyor interviewed Resident # 158, who confirmed Resident # 194's allegation of staff-to-resident physical altercation. Resident # 158 stated that LPN #1 started yelling at Resident # 194 and poked their finger in Resident # 194's face. Resident # 158 stated they were unable to see if the nurse's finger actually touched the resident's skin. Resident # 158 stated that Resident # 194 called LPN #1 a derogatory name and LPN #1 said to Resident # 194, guess what? You're not getting your 7 AM medication from this [derogatory name]. Resident # 158 further stated that LPN #1 stomped on Resident # 194's foot and that Resident # 194 was only wearing flip flops. Resident # 158 stated that LPN #2 and RN #2 came and asked about what happened and that Resident # 158 told them everything they observed. On 01/28/26 at 6:06 PM, the surveyor interviewed RN #1, who stated they entered Resident # 194's room to pass medications the morning of 01/01/26 between 9 AM and 10 AM, when Resident # 194 told RN #1 that they had an altercation with LPN #1. RN #1 stated that Resident # 194 reported that LPN #1 was yelling and said some nasty things to them and stomped on their foot, poking the resident in the forehead which made Resident # 194 call LPN #1 a racial slur. On 01/28/26 at 6:55 PM, the surveyor interviewed the DON, who stated their process when an allegation was made, they interviewed residents or staff who may have witnessed the incident or were in the area where the incident occurred. The DON stated they have a conversation with their regional person to determine if it's a reportable or a grievance, but they did not report all allegations. The DON stated if they did report an allegation of staff-to-resident abuse, the staff member would be removed from the building and not allowed to return until the investigation was completed. The DON confirmed they did not report the allegation that Resident # 194 made. The DON stated they determined it was a grievance and not something that needed to be reported. The DON stated they interviewed other residents and staff who were present at the time the incident occurred, but she did not know which staff or residents were interviewed and was unable to provide any documentation of these interviews and stated they would be provided the next day. The DON stated they were in a locked cabinet that nobody currently in the building had access to and was unable to state why the interviews were not in the folder with the grievance form that was completed related to the allegations. On 01/29/26 at 4:10 PM, the surveyor interviewed the LNHA, who stated that the facility met quarterly for quality assurance and performance improvement (QAPI). The LNHA stated their last meeting was on12/02/25, for the 3rd quarter, and they had not identified any system failures. The LNHA stated he was the point person for all allegations of abuse and was the facility's abuse coordinator. The LNHA stated any allegations of abuse were discussed by the team, and they would collect statements and do their due diligence to find out what happened. The LNHA stated that he honestly felt they came to the right conclusion. The LNHA stated looking back maybe they should have suspended LPN #1, but they still did not feel the allegation warranted that response. NJAC 8:39-9.2(a) NJAC 8:39-9.3(a) NJAC 8:39-27.1(a)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to complete grievances with resolution related to missing personal items after he/she was moved on 08/21/25 by the facility for one of three residents (Resident (R) 133) reviewed for missing items of 40 sample residents. This failure had the potential to affect the resident ability to obtain resolution to grievances.Findings include:Review of R133's undated admission record provided by the facility revealed R133 was admitted on [DATE]. Review of R133's quarterly Minimum Data Set, (MDS) with an Assessment Reference Date (ARD) of 05/26/25, located under the MDS tab of the EMR, indicated the Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 01/28/26 9:59 AM, R133 was asked about an incident that happened on third floor, when he/she moved to second floor on 07/29/25, He/she stated that all of his/her things were to be moved to his/her new room. R133 stated while he/she was out of the facility at dialysis, staff moved her/his belongings. He/she stated when he/she returned, he/she had several items missing. He/she felt at first the items were just not moved down to his/her new room. R133 stated the following items were missing perfume, lotion, two bottles of baby power from second drawer, phone charger, t-shirt with the number 60 on it that he/she got for their birthday to sleep in, in the bottom drawer, two head turbans- one burgundy and one gold. R133 stated he/she talked to the Director of Admissions (DOA)and the Administrative Assistant (AA) about the missing items. R133 stated both had looked for the items but none of the missing items could be located. Review of the Social Service Note dated 05/27/25 at 3:00 PM., indicated the Social Service Director met with the resident to inquire about personal items. The resident indicated something was missing, however, they already know. The resident was offered a lock box to secure her valuables, but he/she declined. R133 presented at her baseline without signs or symptoms of emotional distress. During an interview on 01/30/26 at 10:58 AM, AA was interviewed about the missing items of R133. AA stated they went to the Laundry Supervisor or Supervisor to see if it could be found, wrote a grievance, and gave to the Laundry Supervisor (LS). The AA was asked if this was done with R133's items. The AA stated No, no grievance was written, I went and asked and we looked, but no grievance was written. When asked what happened to R133's items. AA stated the unnamed Certified Nurse Assistants (CNA's) moved his/her items from room, on the third floor and took them to R133's new room on 08/21/25. During an interview on 01/30/26 at 10:15 AM, The DOA stated that R133 refused to allow him/her to pay for items. When asked if there was documentation to this statement, DOA stated he/she had none. The DOA stated neither the DOA nor AA filed out grievance and/or reported this incident per the policy. DOA stated, he/she was asked yesterday 01/29/26 about this incident by the Director of Nursing (DON). He/she stated no grievance was found or filled out by DOA or the AA. When asked what she should have been done at the time it was reported to them, both the DOA and AA stated that a grievance should have been filled out. The DOA stated that when she did not want to pay for the items there should have been documentation of that. AA made the statement we dropped the ball on this report. Review of the facility's policy titled, Resident Grievances Policy, revealed The Facility advises residents and their representatives (including family, legal representatives, and advocates) of their right to file grievances without discrimination or reprisal, and of the process for filing grievances or complaints. The Facility ensures that there is no retaliation for filing a grievance or complaint and ensures that there is a prompt review, investigation, and response to and resolution of grievances and complaints. 4. Grievances and/or complaints may be submitted orally or in writing and can be made anonymously.5. Duties and Obligations of Staff a. When a Facility Staff member receives a complaint from a resident, a resident's representative, or another interested family member of a resident concerning the resident's medical care, treatment, food, clothing, or behavior of other residents, etc., (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Facility Staff member is encouraged to advise the resident that the resident may file a complaint or grievance without fear of reprisal ordiscrimination. NJAC 8:39-4.1(a)35

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to implement their abuse policy and report an allegation of staff to resident abuse for one of five residents (Resident (R) 194) reviewed for abuse out of 40 sample residents. This had the potential to affect residents in the facility who were at risk for abuse.Findings include: Review of R194's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnosis of chronic obstructive pulmonary disease (COPD). Review of R194's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R194 was cognitively intact. During an interview on 01/28/26 at 1:00 PM, R194 stated during the 11 PM to 7 AM shift he/she was in the day room with R158 and R242 watching the ball drop before midnight. His/her head started hurting so he/she went to the nurse cart where Licensed Practical Nurse (LPN) 1 was standing and requested medication. He/she said that LPN1 yelled at him/her and said, Don't you know not to bother me when I'm at the medication cart, so he/she went back into the day room with the other two residents. About forty minutes later LPN1 came into the day room and handed him/her the cup with the medication and R194 said he/she threw it over his/her shoulder and told LPN1 it would be ineffective now since it took so long for it to be administered. At that time LPN1 got down in his/her face and started poking his/her face with his/her fingers on his/her eye and forehead, yelling at him/her and spit was going on his/her face and stomped on his/her right foot. R194 said he/she did it right in front of the cameras. The next morning, he/she reported what happened to Registered Nurse (RN) 1. He/she stated the Administrator in Training (AIT) and another head nurse came in and talked to him/her and apologized for what happened and told him/her that should not have happened and that they were going to review the video from the camera in the day room. During an interview on 01/28/26 at 4:15 PM, R158 (BIMS of 15) confirmed the allegation of R194, stating LPN1 started yelling at R194 and poked his/her finger in R194's face. He/she said LPN2 and RN2 came and asked him/her about what happened and he/she told them everything he/she observed LPN1 do to R194. During an interview on 01/28/26 at 6:06 PM, RN1 said when he/she went into R194's room to pass his/her medications on the morning of 01/01/26 between 9 AM and 10 AM R194 told him/her he/she had an altercation with an evening nurse. RN1 stated he/she immediately notified the in-house supervisor/RN supervisor, and he/she spoke with the Infection Preventionist (IP) who told him/her to complete a skin assessment on R194 which he/she did. During an interview on 01/28/26 at 6:55 PM, the Director of Nursing (DON) stated their process included when an allegation was made, to interview residents or staff who may have witnessed the incident or were in the area where the incident occurred and have a conversation with their regional person and determine if it's a reportable or a grievance, but they did not report all allegations. The DON stated if they did report an allegation of staff to resident abuse, the staff member was removed from the building and not allowed to return until the investigation was completed. He/she confirmed they did not report the allegation that R194 made. He/she said they determined it was a grievance and not something that needed to be reported. During an interview on 01/30/25 at 8:17 AM, the IP said on 01/01/26 he/she was the only nursing supervisor working since it was a holiday. The IP stated he/she was made aware by RN1 that R194 was upset about an incident that occurred during the night shift with LPN1. The IP stated he/she reported after he/she became aware and he/she contacted his/her DON and made him/her aware. Review of the facility's policy titled, Abuse Investigation and Reporting, revised 01/26 revealed .If an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual.An alleged violation of abuse, neglect, exploitation or mistreatment will be reported immediately, but not later than: two (2) hours if the alleged violation involves abuse. NJAC 8:39-9.4(f)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure two of three residents (R) 254 and R230) and their resident representatives reviewed for emergent hospital transfer out of a total sample of 40 residents were provided with a written bed hold policy and transfer notice that contained the appeal process. This failure had the potential to affect the resident and their resident representative (RR) by not having the knowledge of how to appeal the transfer, if desired, and had the potential to contribute to the possible denial of re-admission and loss of the resident's home following a hospitalization for residents transferred to the hospital. Findings include:1.Review of R254's admission Record located under the Profile tab in the electronic medical record (EMR) revealed the resident admitted to the facility on [DATE]. Review of R254's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/09/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R254 was cognitively intact. Review of R254's Progress Note, dated 12/26/25 and located under the Progress Note tab of the EMR, revealed R254 had a change in condition. New order received to send to hospital for evaluation and treatment. Transfer sheet and face sheet provided to Emergency Medical Services (EMS). Review of Notice of Emergency Transfer, dated 12/26/25 and provided by the facility for R254, revealed that the document did not include the appeal process as indicated in the facility's policy. During an interview on 01/30/26 at 3:59 PM, the Social Worker (SW) said the Ombudsman was notified and the Ombudsman information was provided on the transfer form. He/she stated a copy of the transfer form was not provided to the residents because they knew they were going out. He/she stated nothing was documented in their medical record about notification after a transfer and nothing was explained to the residents because they knew they were going out. Review of the facility's policy titled, Transfer or Discharge Notice, revised 04/25, revealed The resident and./or representative (sponsor) will be notified in writing of the following information, A statement of the resident's rights to appeal the transfer or discharge, including: the name, address, email and telephone number of the entity which receives such requests; information about how to obtain, complete and submit an appeal form; and how to get assistance completing the appeal process. 2. Review of R230's quarterly MDS with an ARD of 11/13/25 and located under the MDS tab of the EMR, revealed an admission date of 09/15/21. The quarterly MDS revealed a BIMS score of 15 out of 15 which indicated R230 was cognitively intact; and diagnoses which included coronary artery disease, hypertension, peripheral vascular disease (PVD), diabetes mellitus, other fracture, anxiety disorder, depression, and tobacco use. Review of a nursing note, located under the Notes tab of the EMR, dated 08/14/25, indicating that R230 was sent to the local hospital for evaluation and treatment after a fall in his/her room. Review of the emergency transfer notice, dated 08/14/25 and provided by the facility for R230, revealed the ombudsman office information as the entity for appeals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. Building B. Wing	01/30/2026

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.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/26 at 4:35 PM, the Director of Nursing (DON) stated that was the form for transfers that the facility always used. NJAC 8:39-4.1(a)31,32

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, document review, and interview, the facility failed to ensure assistive devices were provided for one of one resident (Resident (R) 32) reviewed for assistive devices out of 40 sample residents. This had the potential to cause a decrease in the residents' dietary intake. Findings include:Review of R32's Activity Log Report, provided by the facility, dated 12/09/24 at 11:44 AM, revealed R32 was to have a metal tablespoon only Do not send small teaspoon. On 01/08/25 at 11:56 AM, it was noted in the Activity Log Report that he/she was to have no plastic utensils, 2 Large tablespoons only.During an observation and interview on 01/27/26 at 4:40 PM, Certified Nurse Assistant (CNA) 4 was observed feeding R32 and there were two regular spoons (regular dining spoon) on the tray. CNA4 stated this was the way it had been for about a week. CNA4 stated he/she had gotten the two regular spoons on his/her tray. The tray tag notes on it revealed Assist with feeding***Only the circular spoon***.During an observation on 01/28/26 at 4:51 PM, CNA4 was observed feeding R32 with two regular spoons on the tray. CNA4 stated it was the same tonight as last night. The tray tag notes on it revealed Assist with feeding***Only the circular spoon***. The spoon was not on the tray. During an observation on 01/30/26 at 11:20 AM, R32's tray was in his/her room and on the tray was noted to have two regular spoons. The new spoons that were noted to have arrived on 01/29/26 at 3:30 PM were not on his/her tray. During an interview on 01/28/26 at 5:10 PM, the Assistant Director of Dietary (ADOD) stated that the spoon was a soup spoon, and he/she showed a picture of the spoon that he/she was to use. The ADOD stated they ordered them about a week ago. ADOD stated that he/she would get the order sheet, where the spoons were ordered. ADOD stated that with the dishwasher it was not working correctly so they had been sending regular plastic spoons on his/her tray. The dietary tray tag, dated Wednesday Dinner 01/28/26 from his/her supper tray at 4:51 PM, revealed Assist with feeding***Only the circular spoon***. NJAC 8:39-27.5(b)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure proper hand hygiene and use of personal protective equipment (PPE) in the implementation of enhanced barrier precautions, for one of one resident (Resident (R) 12) reviewed for enhanced barrier precautions during a nephrostomy dressing change. In addition, the facility failed to ensure the proper sanitization of a glucometer used to obtain blood glucose results for one of one resident (Resident (R) 90) of three residents reviewed during medication administration observation. This failure had the potential to lead to serious illness and death related to the transmission of blood borne pathogens from resident to resident via the un-sanitized glucometer.Findings include:Findings include: 1.Review of R12's admission Record, located in the Profile tab of the electronic medical record (EMR), revealed R12 was admitted to the facility on [DATE] and re-admitted on [DATE]. R12's diagnoses included renal and perinephric abscess, malignant neoplasm of unspecified kidney, obstructive and reflux uropathy, and type two diabetes mellitus. Review of R12's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab, with an Assessment Reference Date (ARD) of 01/06/26 and 11/20/25 revealed a Brief Interview of Mental Status score (BIMS) score of zero out of 15 which indicated R12 was severely cognitively impaired. The MDS indicated R12 was dependent on staff for toileting hygiene, bathing, and personal hygiene. Review of the most recent Comprehensive Care Plan located in the resident EMR under the Care Plan tab, initiated 09/01/25, indicated R12 was at risk for infection requiring enhanced barrier precautions related to nephrostomy. The interventions included enhanced barrier precautions: use gown and glove during high contact activities, dressing, hygiene, toileting, transferring, bathing/showering, changing linens, device care, wound care, therapy. And perform hand hygiene prior to and after providing care to resident. Review of active Orders located in the EMR under the Orders tab revealed the following order, dated 01/13/25: enhanced barrier precautions. Further review indicated an order for a right nephrostomy tube site cleanse and application of a Tegaderm dressing. During an observation on 01/28/26 at 7:15 PM, Unit Manager (UM) 2 did not perform hand hygiene and did not don (put on) the required PPE (gown, face shield, mask) prior to entering R12's room and removing R12's right nephrostomy dressing. During an interview on 01/28/26 at 7:15 PM, UM 2 stated oh yes, I forget to put on the PPE. UM2 further stated he/she should have donned the PPE prior to doing the nephrostomy dressing change. UM2 stated that he/she forgot to don PPE prior to performing the nephrostomy dressing change. He/she further acknowledged that PPE should have been worn and that he/she should have performed hand washing hygiene, including washing hands with soap and water before and after the dressing change and sanitizing hands. During an interview on 1/29/26 at 10:30 AM, the Infection Preventionist (IP) stated that staff were expected to perform hand hygiene and don appropriate PPE when caring for residents on enhanced barrier precautions. The IP further stated that staff received training on proper PPE use and enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Enhanced Barrier Precautions, revised 10/25, indicated under Definition Enhanced Barrier Precautions refer to an infection control intervention designed to reduce transmission of multi-drug-resistant organisms [MDRO] that requires staff to wear a gown and gloves while performing high contact care activities with all residents who are at higher risk of acquiring or spreading an MDRO. Under Policy Interpretation and Implementation revealed Enhanced barrier precautions will be applied to: .b. Residents with indwelling medical device including central venous catheter, urinary catheter. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised 07/25, indicated This facility considers hand hygiene the primary means to prevent the spread of infections. Under Policy Interpretation and Implementation .2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 2. During a blood glucose monitoring observation on 01/30/26 at 8:10 AM, Licensed Practical Nurse (LPN) 8 received a new glucometer, he/she took the glucometer to the med cart and then into the R90's room. LPN8 then performed a fingerstick blood glucose check for R90. LPN8 performed a handwash but never cleaned the glucometer. LPN8 picked up the glucometer, proceeded back to the B1 hall medication cart where the glucometer was put into the top cart and into its case and placed into the med cart drawer. During an interview on 01/30/26 at 8:25 AM, LPN8 came to the medication cart and at that time was asked about the proper way to clean the glucometer, he/she stated, to use the purple top Santi wipes that are on the cart, pointing to the container and to clean it before and after using the machine. LPN8 stated that it was a new machine, which was why he/she did not clean it. LPN8 stated, it should have been cleaned anyway. All machines were observed for individual residents and not used on other residents. During an interview on 01/30/26 at 3:00 PM, the IP was asked about how to clean the glucometer machine. He/she answered by using the purple Santi wipes that they have on their carts, wash, let dry for three min before and after each use, and they were for individualized use, and each resident has their own that are marked. Review of the facility's policy titled, GLUCOMETERS, reviewed/revised 01/26, revealed 6. Quality controls will be performed on a daily basis - results will be kept in a binder at the nurse's station. 7. Glucometer control solutions and all supplies are to be assessed on a daily basis for signs of contamination and for expiration date. 8. Each glucometer must be wiped down with a sanitizing agent after each use and returned to individual storage. NJAC 8:39-19.4