STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60a005	A. BUILDING: _____ B. WING _____	C 03/14/2024

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SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initials Comments TYPE OF SURVEY: Standard with Complaints COMPLAINT #'s: NJ00149240, NJ00151046, NJ00153350, NJ00155359, NJ00168837 CENSUS: 89 SAMPLE: 20 A Recertification, and Complaint Survey was conducted and it was determined that the faciilty was not in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures And Standards Applicable To All Licensed Facilities	H 000		
H2640	8:43E-10.6(a)(2)(i) Reporting Serious Preventable Adverse Events With respect to serious preventable adverse events related to health care services provided directly to residents of an assisted living residence, comprehensive personal care home or assisted living program by another health care facility, the facility directly providing the service shall report the event to the Department. This REQUIREMENT is not met as evidenced by: Complaint # NJ00153350 Based on interview and record review, it was determined that the facility failed to notify the Department of Health (DOH) of a serious preventable adverse event that was within the control of the facility for 1 of 20 residents	H2640		

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H2640	Continued From page 1	H2640		

reviewed, Resident #2. This deficient practice was evidenced by the following:

On 2/27/24 and 2/28/24 the surveyor reviewed the medical record (MR) of Resident #2, who moved into the facility in NJ EX Order. 264b1 and was pronounced deceased by Emergency Medical Staff on [redacted]. The records revealed Resident #2 was identified as "[redacted]" status. [redacted] required that life support be started by facility staff should a medical emergency occur with the resident.

Upon further review of Resident #2's MR two (2) progress notes (PN), created by Assistant Director of Resident Care (ADON), dated [redacted] documented, "Resident was pronounced by EMT ON NJ EX Order. 264b1 and MD [medical doctor] was notified" and " ... staff was called to residents room by roommate at approximately 4:30 am resident was in the bathroom they moved him/her to the bed to lie down she appeared to [redacted] 911 was called. the [redacted] unit was obtained but not used. Residentceased [sic] (resident [redacted]. NJ EX Order. 264b1 and the nurse was called [redacted] had to call the funeral home. [He/She] was picked up at approximately noon."

During surveyor interview with the Assistant Director of Resident Care (ADON) on 2/27/24 at 2:33 p.m. the surveyor requested a list of employees who worked the night shift of [redacted]. Review of the list revealed two Certified Medication Aides (CMA) and one caregiver worked the night shift on [redacted]

On 2/27/24 at 3:17 p.m. the surveyor interviewed CMA #1 who stated that she was unable to recall the incident on [redacted] but recalls writing it in the

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H2640	Continued From page 2	H2640		

communications book.

At 11:23 a.m. on 2/28/24 the surveyor interviewed CMA #2, who was NJ EX Order. 264b1 certified at the time of the incident, on NJ EX Order. . CMA #2 stated that she remembers writing a "report" for the Executive Director but was unable to recall what the report was for or what was written in the report.

On 2/28/24 at 11:31 a.m. surveyor placed a telephone call out to the third staff member who worked the night shift on NJ EX Order., a caregiver, however, she did not answer the call.

Review of Resident #2's medical record failed to provide any documentation of NJ EX Ord being initiated by CMA #2 upon noting Resident #2 was NJ EX Order. 264b1 despite being a NJ EX Order. 264b status, until the arrival of the emergency medical staff (EMS) in which Resident #2 was then pronounced deceased.

The facility neglected Resident #2 by not initiating NJ EX Order an emergency lifesaving procedure, despite CMA #2 being NJ EX Order certified at the time of the incident.

On 3/4/24 at 12:07 p.m. the surveyor reviewed NJ EX Order. 264b1 Paramedics report number NJ EX Order. 264b which revealed upon EMS arrival, at 4:49 a.m. on NJ EX Order. 2 Resident #2 was " ... found in bed with aide and staff member at the side." Continued review reveal "Facility reported the patient was found at 0320 [3:20 a.m.]. Unknown time when the patient was last seen alive. No NJ EX Order. 264b1 was being performed when EMS arrival. ...". The Paramedic report also revealed " ... Dead without NJ EX Order. 264b1 Efforts."

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H2640	Continued From page 3 On 2/27/24 at 3:11 p.m. the ADON stated she was unable to locate a facility reportable event to the DOH regarding the incident on [redacted] with Resident #2. On 2/28/24 at 9:26 a.m. during interview the Executive Director (ED) stated she did not believe the incident was reported to the DOH. The ED provided the survey team with an acceptable removal plan on 3/7/2024. The surveyor completed a follow-up survey on 3/14/2024 and confirmed that the facility implemented the removal plan.	H2640		
H5750	8:43E-13.4(b) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall complete all sections of the Universal Transfer Form, to the best of the licensed healthcare facility or program's ability. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00149240 Based on interview, and record review it was determined that the facility failed to document a "Universal Transfer Form (UTF)" (a document utilized to communicate pertinent medical information between two medical facilities when a resident is being transferred from one facility to another facility), for 2 out of 20 residents reviewed, Resident #'s 6 and 9. This deficient	H5750		

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H5750	Continued From page 4 practice was evidenced by the following: 1. On [redacted] at 9:39 am., upon entrance into the facility the surveyor observed an ambulance and a police officer in front of the building. Shortly after the surveyor entered the facility, the ambulance departed the facility with Resident #9. On 2/27/24 during the entrance conference with the Executive Director (ED) and the Director of Nursing (DON), the surveyor inquired as to the reason for the ambulance and police at the facility. The DON informed the surveyor that a resident was transported to a local hospital for evaluation. At that time the surveyor requested the UTF. At 3:14 pm, the surveyor was provided a copy of a UTF which had not been completed, there were areas that were left blank. During surveyor interview with the DON regarding the UTF, the DON stated that she would get the UTF for the current transfer and at 3:18 pm provided the surveyor with a UTF that had hand writing on it. The surveyor then informed the DON that the UTF was also incomplete and did not provide complete information on the current transfer, for example: the date, time, where the resident was transferred to, the resident's code status, etc. 2. According to Surveyor review of the Resident #6's UTF, the facility's Nurse did not complete the following information: "Date of Transfer, Time of Transfer AM/PM [morning/night], Reasons for Transfer, Sending Facility Contact: and Form completed by with Title and Phone." Surveyor review of the facility's policy titled, "Transfer Policy with an approval date: June 2022 revealed the following: Under Policy Statement:	H5750		

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H5750	Continued From page 5 "A transfer/discharge form must be completed in Point Click Care (PCC) for all residents who are transferred or discharged from the community." Under Procedure: "Transfer/Discharge form the Community 1. Transfer form must be completed in PCC for all residents for the following reason: Hospital Admission -not returned to the community within 24 hours [,] Universal Transfer form completed for all transfers (NJ (New Jersey) only) 2. The Wellness Nurse will complete the transfer form in PCC for ...Completed for all transfers in NJ ..." During an interview on 2/28/24 at 1:50 p.m., when the surveyor asked about Resident #6's UTF, and who should complete the form, the DON stated "the universal transfer [form] is completed by whoever sends the resident out at the time of transfer, it is filled in handwritten with date and time and signed at the bottom."	H5750		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard with Complaint Complaint #'s: NJ00149240, NJ00151046, NJ00153350, NJ00155359, NJ00168837 CENSUS: 89 SAMPLE: 20 A Standard and Complaint survey was conducted by the State Agency on 2/27/2024 and 2/28/2024. The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences,	A 000		

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A 000	Continued From page 6 Comprehensive Personal Care Homes, and Assisted Living Programs, based on this survey.	A 000		
A 235	8:36-2.4(d) Licensure Procedures (d) Survey visits may be made to a facility at any time by authorized staff of the Department. Such visits may include, but not be limited to, the review of all facility documents and resident records and conferences with residents. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ00149240, NJ00151046, NJ00153350, NJ00155359, NJ00168837 Based on interview, and record review it was determined the facility failed to provide the surveyors with full access to the electronic medical record (EMR) for review for 20 of 20 residents reviewed. This deficient practice was evidenced by the following: On 2/27/24 at 10:00 a.m., during the entrance conference, the surveyor requested full access to the facility's EMR. At that time the facility's Administrator (Adm) stated that he would be able to provide the surveyors with full access to the EMR. In the presence of the Adm, when the surveyor asked if any of the medical record (MR) was on paper, the Director of Nursing (DON) stated that all medical records were in PCC (Point Click Care), and that the facility transitioned to the EMR system a year ago.	A 235		

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A 235	Continued From page 7 At approximately 11:00 a.m., the surveyors were provided with login information for the EMR. At 1:09 p.m., the surveyor tried to access Resident #5's Progress Notes (PNs) and electronic Medication Administration Record (eMAR) in the EMR but was unable to view them. When the surveyor informed the Adm, he stated that the eMAR was in PCC/the EMR, however, the surveyor was unable to access it. At 1:45 p.m., the surveyor requested full access to the EMR a second time from the DON. At 2:00 p.m., the surveyor tried to access the EMAR for June 2022 for Resident# 5 a second time and was still unable to access the EMAR. At 2:20 p.m., the surveyor requested full access to include the EMAR & Physician's Orders, however full access was still not provided to the surveyors. On 2/27/24 at 2:59 p.m., Surveyor #2 informed the facility that they will receive a deficiency for not providing full access to the EMR. On 2/28/24 at 9:30 a.m., the surveyor was still not able to login with full access to the EMR. The surveyor was not granted full access to the EMRs for the all residents reviewed but was provided paper copies of some of the requested documents from the facility EMRs.	A 235		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following:	A 310		

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A 310	Continued From page 8 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint # NJ153350 Based on interview, record review, and pertinent facility documentation, it was determined that the facility Executive Director (ED) failed to implement and enforce the policies and procedure titled, "Cardio Pulmonary Resuscitation (CPR)," "Call Bell Response/Signaling," "First Aid and Emergency Procedures," "Fall Reduction and Response to Falls," and "Incident/Accident Reports ~ Risk Management" regarding a resident fall and expiration for 1 of 20 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 2/27/24 and 2/28/24 the surveyor reviewed the medical record (MR) of Resident #2, who moved into the facility in NJ EX Order: 26461 and was pronounced deceased by Emergency Medical Staff on NJ EX Order:. On 2/27/24 at 1:30 p.m. the surveyor reviewed a document titled, "Detailed Event Report" (this is	A 310		

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A 310	Continued From page 9	A 310		

used to record the pendant response times), which revealed that on NJ EX Order. 264b1 Resident #4 pressed his/her NJ EX Order. 264b1, and waited NJ EX Order. 264b1, from NJ EX Order. 264b1 a.m., until the NJ EX Order. 264b1 was cleared.

Surveyor interview with Resident #4 on NJ EX Order. 264b1 at 10:23 a.m. revealed that he/she pressed their NJ EX Order. 264b1 staff on NJ EX Order. 264b1 when he/she had got up in the middle of the night to use the bathroom and saw their roommate, Resident #2, on the floor in the bathroom. Resident #4 continued to state he/she waited "NJ EX Order. 264b1 NJ EX Order. 264b1 until someone came.

Upon further review of Resident #2's MR two (2) progress notes (PN), created by Assistant Director of Resident Care (ADON), dated NJ EX Order. 264b1 documented, "Resident was pronounced by EMT on NJ EX Order. 264b1. NJ EX Order. 264b1 and MD was notified" and " ... staff was called to residents room by roommate at approximately 4:30 am resident was in the bathroom they moved him/her to the bed to lie down she appeared to NJ EX Order. 264b1 911 was called. the AED unit was obtained but not used. Residentceased [sic] (resident NJ EX Order. 264b1. NJ EX Order. 264b1 and the nurse was called NJ EX Order. 264b1 had to call the funeral home. [He/She] was picked up at approximately noon."

Surveyor interview with the ADON on 2/27/24 and 2/28/24 reveal she received a telephone call from one of the two Certified Medication Aides (CMA) who worked the overnight shift on NJ EX Order. 264b1 into NJ EX Order. 264b1 regarding the incident, yet was unable to recall which aide she received the call from. The ADON continue to state she directed the staff, via telephone, to get the NJ EX Order. 264b1 and call 911. The ADON was unable to recall if she directed the staff to start

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A 310	Continued From page 10 NJ EX Order. 264b1) nor if she knew the resident's code status at the time, she directed the staff to obtain the NJ EX Order yet wanted to staff to have it available if needed. Continue interview with the ADON revealed that at least one of the two CMAs working that night was NJ EX Order certified and upon noting a resident is NJ EX Order. 264b1 and a NJ EX Order. 264b status CPR should be initiated. As per the ADON the facility no longer has the communication book from NJ EX Order. of NJ EX Order nor do they have the assignment sheet from NJ EX Order. 264b1 On 2/27/24 at 3:11 p.m. the ADON stated she was unable to locate an incident report investigation nor a facility reportable event to the Department of Health regarding the incident on NJ EX Order. with Resident #2. Review of Resident #2's medical record failed to provide any documentation of NJ EX Order being initiated by CMA #2 upon noting Resident #2 was NJ EX Order. 264b1 despite being a NJ EX Order. 264b status, until the arrival of the emergency medical staff (EMS). On 3/4/24 at 12:07 p.m. the surveyor reviewed NJ EX Order. 264b1 Paramedics report number NJ EX Order. 264b which revealed upon EMS arrival, at 4:49 a.m. on NJ EX Order Resident #2 was " ... found in bed with aide and staff member at the side.". Continued review reveal "Facility reported the patient was found at 0320 [3:20 a.m.]. Unknown time when the patient was last seen alive. No NJ EX Order. 264b1 was being performed when EMS arrival. ...". The Paramedic report also revealed " ... Dead without NJ EX Order. 264b1 Efforts." Surveyor review of the following facility policies and procedures revealed:	A 310		

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A 310	Continued From page 11 1. "Cardio Pulmonary Resuscitation (CPR)," with an approval date of 2/2013, which indicated, "All staff certified in Cardio Pulmonary Resuscitation (CPR) will initiate CPR on any resident found to have suffered a cardiopulmonary/respiratory arrest with FULL CODE status. ... Document the occurrence in the Resident Record." 2. "Call Bell Response/Signaling" with a revision date of 01/2023, which indicated", " ... A response to resident's call bell and/or pendent must be answered within 8 minutes. Call Bell and/or Pendant must be deactivated at the time of arrival to the resident's room or location. ..." 3. "First Aid and Emergency Procedures" with a revision date of 03/2011, which indicated " ... 8. Basic emergency care to support the resident will occur until the emergency team arrives; any advance directive will be honored." 4. "Fall Reduction and Response to Falls" with a revision date of 12/2018, which indicated, " ... 5. The fall is documented in the resident's medical record and on the incident report. Documentation includes Objective description of how the resident was found ... First aid and other care provided ..." 5. "Fall Reduction and Response to Falls" with a revision date of 10/2023, which indicated, " ... 5. Complete all sections of the Incident/Accident Report designated in PCC which include the following: a. Details~ of incident b. Injuries~ if observed c. Paint Tool/Scale ~ Observed or verbalized d. Factors ~ which may have contributed to incident e. Witness ~ if staff or other present f. Actions ~ call physician family DRC [Director of Residential Care] g. Notes ~ documentation implementation & follow up ... 8. All incident reports must be reviewed and signed by the director a resident service and the executive director within 48 hours of the incident.	A 310		

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A 310	Continued From page 12 9. Types of incidents/accidents to be reported; but not limited to: Falls; including resident found on the floor ... 12. Allstate reportable incidents must be reported to the state department within 24 hours of the event. ..." The facility failed to follow its own above policies and procedures. The ED provided the survey team with an acceptable removal plan on 3/7/2024. The surveyor completed a follow-up survey on 3/14/2024 and confirmed that the facility implemented the removal plan.	A 310		
A 357	8:36-4.1(a)(2) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 2. The right to receive a level of care and services that addresses the resident's changing physical and psychosocial status; This REQUIREMENT is not met as evidenced by: Complaint # NJ00153350 Based on interview, medical record, and pertinent facility documentation review, it was determined	A 357		

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A 357	Continued From page 13	A 357		

that the facility failed to ensure a resident received a level of care and services which addressed the resident's changing physical status for 1 of 20 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 2/27/24 and 2/28/24 the surveyor reviewed the medical record (MR) of Resident #2, who moved into the facility in NJ EX Order. 264b1 and was pronounced deceased by Emergency Medical Staff (EMS) on NJ EX Order. 2

Upon further review of Resident #2's MR two (2) progress notes (PN), created by Assistant Director of Resident Care (ADON), dated NJ EX Order. 2 documented, "Resident was pronounced by EMT on NJ EX Order. 2. Daughter and MD was notified" and " ... staff was called to residents room by roommate at approximately 4:30 am resident was in the bathroom they moved him/her to the bed to lie down NJ EX Or appeared to NJ EX Order. 264b1 911 was called. the NJ EX Order unit was obtained but not used. Residentceased [sic] (resident NJ EX Order. 264b1 and the nurse was called NJ EX Order. 264b1 had to call the funeral home. [He/She] was picked up at approximately noon."

During surveyor interview with the ADON on 2/27/24 at 2:33 p.m. the surveyor requested a list of employees who worked the night shift of NJ EX Order. 2 Review of the list revealed two Certified Medication Aides (CMA) and one caregiver worked the night shift on NJ EX Order. 2

On 2/27/24 at 3:17 p.m. the surveyor interviewed CMA #1 who stated that she was unable to recall the incident on NJ EX Order. 2 but recalls writing it in the communications book.

At 11:23 a.m. on 2/28/24 the surveyor interviewed

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 357	Continued From page 14 CMA #2, who was NJ EX Ord certified at the time of the incident, regarding the incident on NJ EX Order 2. CMA #2 stated that she remembers writing a "report" for the Executive Director but was unable to recall what the report was for or what was written in the report. On 2/28/24 at 11:31 a.m. surveyor placed a telephone call out the third staff member who worked the night shift on NJ EX Order 2, a caregiver, yet she did not answer. On 3/4/24 at 12:07 p.m. the surveyor reviewed Atlantic Ambulance Paramedics report number 22-7821 which revealed upon EMS arrival, at 4:49 a.m. on NJ EX Order 2, Resident #2 was " ... found in bed with aide and staff member at the side.". Continued review reveal "Facility reported the patient was found at 0320 [3:20 a.m.]. Unknown time when the patient was last seen alive. No NJ EX Order: 264b1 was being preformed when EMS arrival. ...". The Paramedic report also revealed " ... Dead without NJ EX Order: 264b1 Efforts." Based on review of the paramedics report the facility staff found Resident #2 around 3:20 a.m. yet EMS did not receive a call until 4:40 a.m., which is a time lapse of one hour and NJ EX mins. According to facility policy "First Aid and Emergency Procedures" with a revision date of 03/2011, " ... 8. Basic emergency care to support the resident will occur until the emergency team arrives; any advance directive will be honored." The facility failed to ensure Resident #2 received care and services which addressed her physical status change when staff found the resident on NJ EX Order 2	A 357		

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A 357	Continued From page 15 The Executive Director (ED) provided the survey team with an acceptable removal plan on [redacted] The surveyor completed a follow-up survey on 3/14/2024 and confirmed that the facility implemented the removal plan.	A 357		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaint # NJ00153350 Based on interview, medical record, and pertinent facility documentation review, it was determined that the facility failed to ensure that each resident's right to be free from neglect was enforced for 2 of 20 residents reviewed, Resident #2 and #4. This deficient practice was evidenced by the following: On 2/28/24 at 10:23 a.m. the surveyor interviewed Resident #4 who stated he/she	A 389		

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A 389	Continued From page 16	A 389		

pressed their NJ EX Order. 264b1 alert staff on NJ EX Order. when he/she had got up in the middle of the night to use the bathroom and saw their roommate, Resident #2, on the floor in the bathroom. Resident #4 continued to state he/she waited "at least NJ EX Order. 264b1 " until someone came.

On 2/27/24 at 1:30 p.m. the surveyor reviewed a document titled, "Detailed Event Report" (this is used to record the pendant response times), which revealed that on NJ EX Order. Resident #4 pressed his/her NJ EX Order. nt NJ EX O times, and waited NJ EX Order. 264b1, from NJ EX Order. 264b1 a.m., until the NJ EX Order. 264b1 was cleared.

According to the facility policy titled Call Bell Response/Signaling" with a revision date of 01/2023, " ... A response to resident's call bell and/or pendent must be answered within 8 minutes. Call Bell and/or Pendant must be deactivated at the time of arrival to the resident's room or location. ..."

On 2/27/24 and 2/28/24 the surveyor reviewed the medical record (MR) of Resident #2, who moved into the facility in NJ EX Order. 264b1 and was pronounced deceased by Emergency Medical Staff on NJ EX Order. 2

Upon further review of Resident #2's MR two (2) progress notes (PN), created by Assistant Director of Resident Care (ADON), dated NJ EX Order. 2 documented, "Resident was pronounced by EMT on NJ EX Order. 264b1 and MD was notified" and " ... staff was called to residents room by roommate at approximately 4:30 am resident was in the bathroom they moved him/her to the bed to lie down NJ EX Orde appeared to NJ EX Order. 264b1 911 was called. the NJ EX Orde unit was obtained but not used. Residentceased [sic] (resident

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NJ EX Order. 264b1 and the nurse was called NJ EX Order. 264b1 had to call the funeral home. [He/She] was picked up at approximately noon."

On 2/27/24 at 3:17 p.m. the surveyor interviewed CMA #1 who stated that on the overnight shift, 11:00 p.m. to 7:00 a.m., a CMA should always be the wellness office, a nurse's station, to acknowledge if a call bell goes off. CMA #1 continued to state that prior to the facilities current electronic health record (EMR), paper charts were used and stored in the wellness office. CMA #1 also stated that she was unable to recall if she was the CMA in the wellness office that night, as there were two CMAs on the schedule, nor was she able to recall the incident yet did recall writing something in the communication book.

At 11:23 a.m. on 2/28/24 the surveyor interviewed CMA #2, who was CPR certified at the time of the incident, regarding the incident on NJ EX Order. 2 CMA #2 stated that she remembers writing a "report" for the Executive Director but was unable to recall what the report was for or what was written in the report.

On 2/28/24 at 11:31 a.m. surveyor placed a telephone call out the third staff member who worked the night shift on NJ EX Order. , a caregiver, yet she did not answer.

Surveyor interview with the ADON on 2/27/24 and 2/28/24 reveal she received a telephone call from one of the two Certified Medication Aides (CMA) who worked the overnight shift on 3/8/24 into NJ EX Order. , regarding the incident, yet was unable to recall which aide she received the call from. The ADON continue to state she directed the staff, via telephone, to get the NJ EX Order. 264b1

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A 389	Continued From page 18 NJ EX Order. 264b1) and call 911. The ADON was unable to recall if she directed the staff to start NJ EX Order. 264b1) nor if she knew the resident's code status at the time, she directed the staff to obtain the AED yet wanted to staff to have it available if needed. Continue interview with the ADON revealed that at least one of the two CMAs working that night was NJ EX Order certified and upon noting a resident is unresponsive and a NJ EX Order. 264b1 status NJ EX Order should be initiated. As per the ADON the facility no longer has the communication book from NJ EX Order. 2 of NJ EX Order nor do they have the assignment sheet from NJ EX Order. 264b1. Review of Resident #2's medical record failed to provide any documentation of NJ EX Order being initiated by CMA #2 upon noting Resident #2 was NJ EX Order. 264b1 despite being a NJ EX Order. 264b status, until the arrival of the emergency medical staff (EMS). The facility neglected Resident #2 by not initiating NJ EX Order an emergency lifesaving procedure, until the arrival of EMS. The facility also neglected Resident #4 by leaving his/her call bell unanswered for NJ EX Order. 264b1 despite the facility's policy allotted time of eight minutes. The Executive Director (ED) provided the survey team with an acceptable removal plan on NJ EX Order. 264b1 The surveyor completed a follow-up survey on 3/14/2024 and confirmed that the facility implemented the removal plan.	A 389		

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A 547	Continued From page 19	A 547		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following: 6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice education, and evaluation of job performance; This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to implement its policies titled, "Hiring New Associates", and "Job Descriptions" when it was determined that personnel files for 6 of 10 staff were not complete. This deficient practice was evidenced by the following: On 2/28/24 the surveyor requested and received personnel files for 10 facility staff. The surveyor observed that 6 of the 10 personnel files were missing various sections of the required	A 547		

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A 547	Continued From page 20 documents as follows: 1. Four of the 10 were missing application/education/and work history 2. Two of the 10 were missing the job description 3. Four of the 10 were missing reference checks and or criminal background checks 4. One of the 10 did not have the license number and expiration date check 5. Four of the 10 did not have current or any Cardiopulmonary Resuscitation/Automated External Defibrillator certification included in the file 6. One of 10 did not have a current history and physical in the health portion of the personnel file 7. Two of 10 did not have updated tuberculosis testing or chest xray documentation in the health portion of the file 8. Five of the 10 did not have updated and complete mandatory training in the areas of Emergency Drills, Assisted Living Concepts, Resident Rights, Infection Control, and Emergency Training. The surveyor reviewed the facility policy titled, "Hiring New Associates", which indicated in part, "...All candidates must complete an application, reference check authorization, and background check authorization. All candidates extended an offer of employment, must go through a background check, upon starting, orientation and designated training for their position." Additionally, the surveyor reviewed the facility policy titled, "Job Descriptions", which indicated in part the following: "All associates are to have a signed job description in their personnel file."	A 547		
A 709	8:36-7.2(d)(1-18) Resident Assessments and Care Plans	A 709		

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A 709	Continued From page 21 (d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following: 1. Need for assistance with "activities of daily living"; 2. Cognitive patterns; 3. Communication/hearing patterns; 4. Vision patterns; 5. Physical functioning and structural problems; 6. Continence; 7. Psychosocial well-being; 8. Mood and behavior problems; 9. Activity pursuit patterns; 10. Disease diagnoses; 11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle; 12. Oral/nutritional status; 13. Oral/dental status; 14. Skin conditions; 15. Medication use;	A 709		

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A 709	Continued From page 22 16. Special treatment and procedures; 17. Restraint use; 18. Outside service utilization. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00149240 Based on interview and record review on 2/28/24, it was determined that the facility failed to ensure that an assessment was completed by a Registered Nurse (RN) for 1 of 3 residents, Resident #6. This deficient practice was evidenced by the following: On 02/28/24 at 11:00 a.m., the surveyor reviewed the Medical Record (MR) of Resident #6 which documented that the resident was originally admitted to the facility on [NJ EX Order. 264b1] and readmitted on 11/[NJ EX Order. 264b1] with diagnoses which included NJ EX Order. 264b1. The surveyor reviewed Resident #6's "Shared Risk Agreement (SRA)" dated 3[NJ EX Order. 264b1], with a review every 90 days, which revealed that the resident requested the use of a NJ EX Order. 264b1) to get in and out of bed. During an interview at 11:49 a.m., the surveyor asked the DON how often residents were reassessed for [NJ EX Order. 264b1], she stated "the risk assessment for [the] [NJ EX Order. 264b1] is every [NJ E] months." She continued to say that she would check on the last assessment completed for Resident #6.	A 709		

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A 709	Continued From page 23 In a second interview at 1:50 p.m., the surveyor asked the process for obtaining a [redacted], the DON stated that the process was as follows, "the resident goes through Physical Therapy (PT) sessions, PT recommends [redacted] or [redacted]. The assessment is annually unless a change, and the Assessment is done by a RN." She continued to say that Resident #6 does not have a current [SRA] and needs a new one completed. A review of the facility policy titled, "Assessment Tool", with a revised date April 2010 revealed the following under Policy: "To assure that each resident's service needs are identified and documented for implementation of resident care services." Under Procedure: " ...The Director of Resident Care or designee re-assesses the resident thirty (30) days after move-in. Re-assessments are also completed every 120 days thereafter (or more frequently should state law require it) and upon change in condition..."	A 709		
A 963	8:36-11.5(f) Pharmaceutical Services (f) Medications shall be accurately administered and documented by properly authorized individuals, in accordance with prescribed orders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure medications were administered to	A 963		

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A 963	Continued From page 24	A 963		

residents in accordance with prescriber's orders and the facility failed to document the rationale as to why the prescribed medications were not administered for 3 of 20 residents reviewed for medication administration, Residents: #5, #7 and #8. This deficient practice was evidenced by the following:

On 2/27/24 at 11:41 a.m, the surveyor interviewed a Licensed Practice Nurse (LPN) and asked how medications were refilled. The LPN stated that if a medication could be refilled, the prescription is faxed to the Pharmacist, if the Pharmacist needs a new prescription, the primary doctor is contacted and the doctor sends the prescription to the Pharmacy.

In continued interview, the LPN stated that if the medication was not available, the nurses let the resident and doctor know and the reason is documented on the eMAR (electronic Medical Administration Record). If a medication is not given, there is a code on the eMAR. The LPN stated that she was not sure if a Nurses' Note would also be written.

1. On 2/27/24 around noon., Surveyor #1 interviewed Resident #5 about his/her medications missed in NJ EX Order. 264b1, he/she stated that when they first arrived to the facility, he/she did not get his/her medications in a timely manner.

Surveyor #1 reveiwed Resident #5's MR and observed that Resident #5 had a Move In Date of NJ EX Order. 264b1 and diagnoses which included NJ EX Order. 264b1 Further review of Resident #5's PNs revealed no notes for NJ EX Order. 264b1. Resident #5's MR also included an eMAR for the

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A 963	Continued From page 25 month of NJ EX Order. 264b2 which revealed Resident #5 did not receive his/her prescribed medication NJ EX Order. 264b1 NJ EX Order. 264b1 on NJ EX Order. 264b1 and NJ EX Order. 264b1. The medication was documented with a 9, which indicated the medication was not administered as prescribed. During an interview at 11:09 a.m., when Surveyor #1 asked the Director of Nursing (DON) about Resident #5's chart code "9", she stated the "9" means "other" to see the PNs. The surveyor observed that there was no PNs for Resident #5 regarding medication administration. Additionally, Medication Technicians give the medications and they do not chart on the PNs. 2. At 11:10 a.m., the surveyor reviewed Resident #7's MR and observed an original Move in Date of NJ EX Order. 264b2 additonally, was readmitted on NJ EX Order. 264b1 and a diagnosis which included NJ EX Order. 264b1 and NJ EX Order. 264b1. Resident #7's MR also included an eMAR for the month of NJ EX Order. 264b1 which revealed that Resident #7 did not receive his/her prescribed medication as listed below: NJ EX Order. 264b1 milligrams was not administered as prescribed on 1/5/2022, 1/6/2022, 1/21/2022, and 1/23/2022. NJ EX Order. 264b1 milligrams was not administered as prescribed on 1/29/2022 and 1/30/2022. NJ EX Order. 264b1 milligrams was not administered as prescribed on 1/10/2022 and 1/15/2022. NJ EX Order. 264b1 was not administered as prescribed on 1/11/2022.	A 963		

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A 963	Continued From page 26 The above medications, and the corresponding dates, were documented with a 9, which indicated the medication was not administered as prescribed. The surveyor did not receive Resident #7's requested PNs for the month of January 2022. 3. On 2/28/2024 at 10:17 a.m., Surveyor #2 interviewed Resident #8 who stated that he/she did not receive his/her night-time medication named [redacted] (an[redacted] and [redacted]). During continued surveyor interview, Resident #8 stated that he/she missed 4 or 5 doses of [redacted] during the month of February. At 10:25 a.m., Surveyor #2 interviewed the Certified Medication Aide (CMA) and requested to review Resident #8's eMAR for the month of [redacted]. The surveyor observed on the eMAR that Resident #8 [redacted] was not administered as prescribed on 2/21/2024, 2/23/2024, 2/26/2024, and on 2/27/2024. During continued surveyor interview, the CMA stated that a check mark is utilized to indicate that a medication was administered as prescribed. On 2/21/2024, 2/23/2024, 2/26/2024 and on 2/27/2024, the number 9 was documented on Resident #8's electronic MAR, instead of a check mark. According to the codes on the eMAR, Resident #8's [redacted] was not administered. Continued surveyor interview with the CMA revealed that the number 9 means the medication was not administered as prescribed, due to the medication not being received from the pharmacy.	A 963		

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A 963	Continued From page 27 Further review of the chart code located on Resident #8's eMAR revealed that the number 9 indicates "other", which refers the reader to review the Resident's Progress Notes (PNs) (a written record that captures the details of a patient's health status, treatment progress, and any changes in their clinical condition). At 10:45 a.m., the surveyor reviewed Resident #8's Medical Record (MR) and observed a document titled, "MOVE IN RECORD (MIR)," which indicated a Move In Date of NJ EX Order. 264b1 and diagnoses which included NJ EX Order. 264b1 . At 11:45 a.m., the surveyor interviewed the DON who stated that the number "9" on the chart code did not indicate that the medication was not administered as prescribed due to not being received from the pharmacy but that the medication was not administered for a reason that did not have a specific chart code reason listed. During continued surveyor interview, the DON stated that Resident #8 did not have PNs for the month of NJ EX Order. 264b1. The DON also stated that PNs were not created to reveal why Resident #8's NJ EX Order. 264b1 was not administered as prescribed but that PNs should have been created to indicate why the medication was not administered as prescribed. Surveyor reviewed the facility policy tilted, "Medication Administration" which revealed, Under Policy: "The qualified person administering medication will provide safe and accurate administration to the residents requiring assistance with administration of medication." Under Standards: "...10. The person	A 963		

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A 963	Continued From page 28 administering records the medication given on the Medication Administration Record. If the resident refuses the medication, he/she indicates the failure to administer on the MAR and in the resident nurses progress note..."	A 963		
A1023	8:36-14.1(a) Emergency Services and Procedures (a) Emergency medical services shall be available to or arranged for residents requiring these services. This REQUIREMENT is not met as evidenced by: Complaint # NJ00153350 Based on interview, record review and pertinent facility document, it was determined that the facility failed to provide Cardiopulmonary resuscitaion (CPR) for 1 of 20 residents, Resident #2. This deficient practice was evidenced by the following: On 2/27/24 and 2/28/24 the surveyor reviewed the medical record (MR) of Resident #2, who moved into the facility in NJ EX Order: 26401 and expired on NJ EX Order at the facility and was pronounced by Emergency Medical Technician (EMT) at the scene. Further, the record revealed Resident #2 was a NJ EX Order: 26401 " which required NJ EX Order: 26401 is an emergency life-saving procedure that is done when someone's breathing or heartbeat has stopped. Continued review of Resident #2's MR revealed	A1023		

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A1023	Continued From page 29	A1023		

Progress Notes (PN), written by the Assistant Director of Resident Care who was also a Registered Nurse (ADON), dated [redacted] which documented, "Resident was pronounced by EMT on [redacted] and MD was notified" and " ... staff was called to residents room by roommate at approximately 4:30 am resident was in the bathroom they moved him/her to the bed to lie down [redacted] appeared to [redacted] 911 was called. the [redacted] unit was obtained but not used. Resident ceased [sic] (resident [redacted] ... and the nurse was called [redacted] had to call the funeral home. ... [Resident]was picked up at approximately noon."

The surveyor then requested a list from the ADON of employees who worked and provided care to the resident during the night shift on [redacted] The list identified two Certified Medication Aides (CMA) and one Caregiver during the night shift on [redacted]

On 2/27/24 at 3:17 p.m. the surveyor interviewed CMA #1 regarding the above incident and the CMA stated that she was unable to recall the incident on [redacted] but recalled documenting it in the communication book.

On 2/28/24 at 11:23 a.m., the surveyor interviewed CMA #2, who was CPR certified at the time of the [redacted] incident. CMA #2 stated that she recalled writing a "report" for the Executive Director (ED) but was unable to recall what the report was for or what was written in the report.

On 2/28/24 at 11:31 a.m. the surveyor placed a telephone call to the Caregiver but the surveyor was unable to reach the Caregiver.

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A1023	Continued From page 30 The surveyor interviewed the ADON on 2/27/24 at 2:33 p.m., and on 2/28/24 at 10:46 a.m., regarding Resident #2. The ADON stated she received a telephone call from one of the CMAs [unable to recall the CMA] regarding Resident #2 not being NJ EX Order. 264b1 on the morning of NJ EX Order. The ADON continued to state she directed the staff, via telephone, to obtain the NJ EX Order. 264b1 and call 911. The ADON stated she was unable to recall if she directed the staff to start NJ EX Order. 264 not based on the resident's code status at the time. The ADON explained that one of the CMAs was NJ EX Orde certified and should have initiated NJ EX Orde upon noting the resident was unresponsive without pulse and a NJ EX Order. 264 status. On 2/28/24 at 11:49 a.m. the surveyor reviewed the facility policy titled "Cardio Pulmonary Resuscitation (CPR)," with an approved date of 2/2013, which indicated, "All staff certified in Cardio Pulmonary Resuscitation (CPR) will initiate CPR on any resident found to have suffered a cardiopulmonary/respiratory arrest with FULL CODE status. ... Document the occurrence in the Resident Record." The facility failed to follow its own policy. The ED provided the survey team with an acceptable removal plan on NJ EX Order. 264b1 The surveyor completed a follow-up survey on 3/14/2024 and confirmed that the facility implemented the removal plan.	A1023		
A1051	8:36-15.2 Resident Records The records required by this subchapter shall be maintained for all residents and shall be kept	A1051		

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A1051	Continued From page 31 available on the premises for review at any time by representatives of the Department. This REQUIREMENT is not met as evidenced by: Complaint #'s: NJ00149240, NJ00151046, NJ00153350, NJ00155359, NJ00168837 Based on interview, and record review it was determined that the facility failed to ensure requested Medical Records were available for review to the surveyors for 2 of 20 residents reviewed, Resident #'s 7 & 8. This deficient practice was evidenced by the following: On 2/27/24 at 10:00 a.m., during the entrance conference, the surveyor requested full access to the facility's EMR. At that time the facility's Administrator (Adm) stated that he would be able to provide the surveyors with full access to the EMR. At approximately 11:00 a.m., the surveyors were provided with login information, username and password to gain access to the EMR. At 1:09 p.m., the surveyor tried to access Resident #5's Progress Notes (PNs) and electronic Medication Administration Record (eMAR) in the EMR but was unable to view them. When the surveyor informed the Adm he stated that the eMAR is in PCC, (Point Click Care, the EMR), however, the surveyor was unable to access it. At 1:45 p.m., the surveyor requested full access to the EMR a second time from the Director of Nursing (DON).	A1051		

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A1051	Continued From page 32 At 3:30 p.m., during surveyor interview with the DON, Surveyor #1 requested documentation for a list of sampled Residents #'s: 1, 2, 3, 4, 5, 6, 7, 8 & 9. On 2/28/24 at 9:30 a.m., the surveyor was still unable to login with full access to the EMR. On 2/28/24 at 10:02 a.m., the survey team still had not received full access to the facility's EMR system. On 2/28/2024 at 11:11 a.m., Surveyor #2 received some of the requested documents from the DON. At that time, the surveyor requested additional documents from the facility's DON for the sampled residents. At 11:20 a.m., Surveyor #2 reviewed the documents received from the DON which revealed the following: Resident #7's medical record had a Move in Date of NJ EX Order. 264b1 and diagnoses which included NJ EX Order. 264b1. The surveyor did not observe any Physician Order Sheets among the documents provided. The surveyor reviewed Resident #8's medical record and observed documented a Move in Date of NJ EX Order. 264b1 and diagnoses which included NJ EX Order. 264b1 r and NJ EX Order. 264b1. Further review of the documents received revealed the facility did not provide the surveyor with Resident #8's requested PNs and the resident's most recent Registered Nurse (RN) assessment. At 11:45 a.m., during surveyor interview, the facility's DON informed Surveyor #2 that if the	A1051		

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A1051	Continued From page 33 requested document was not received, the facility did not have the requested documents.	A1051		
A1235	8:36-17.5(a)(3)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. Residents may have individually controlled thermostats in residential units in order to maintain temperatures at their own comfort level. 3. During warm weather conditions, the temperature within the facility shall not exceed 82 degrees Fahrenheit. i. The facility shall provide for and operate adequate ventilation in all areas used by residents. ii. All areas of the facility used by residents shall be equipped with air conditioning and the air conditioning shall be operated so that the temperature in these areas does not exceed 82 degrees Fahrenheit. This REQUIREMENT is not met as evidenced by: Complaint #NJ00168837 Based on interview and facility document and policy review, the facility failed to maintain the heating and air conditioning system in accordance with the provisions of New Jersey Administrative Code (NJAC) 8:36-17.5. The deficiency affected 1 of 3 floors where residents	A1235		

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resided.

Findings included:

1. Review of a facility policy titled, "Heating and Air Conditioning," revised in January 2015, revealed "Heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents." The policy revealed "4. All equipment owned and operated by the community shall be kept in good working condition. 5. Maintenance keeps emergency heating sources for use in an emergency. The maintenance department shall continually monitor all emergency-heating conditions until resolved."

Review of an undated facility policy titled "Heating, Ventilation and Air Conditioning System," revealed "The Community shall maintain and service the Heating, Cooling, Air Condition and Ventilation (HVAC) systems to ensure a comfortable environment for residents." The policy revealed "HVAC systems should be adequate to maintain an indoor space temperature between 68 deg [degrees] F [Fahrenheit] and 81 deg F depending on seasonal temperatures."

Review of a "Work Order," dated 08/03/2023, indicated there was no air conditioning on the third floor, and 90% of the furnace was "red tagged" by a gas company in 2021. The document revealed "system must be replaced."

Review of an "Estimate," dated 08/08/2023, indicated replacement of the third-floor common area HVAC unit was completed on 01/10/2024.

A review of Resident #8's "Move In Record"

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revealed the facility admitted the resident on 09/27/2022 with diagnoses that included major depressive disorder, heart failure, and hypertension.

A review of Resident #5's "Move In Record" revealed the facility admitted the resident on 12/03/2021 with diagnoses that included chronic heart failure, hypertension, and a history of falling. During an interview on 02/27/2024 at 12:46 PM, Resident #8 stated that the facility was without heat in the hallways on the third floor for about five months in 2023 to January 2024. The resident stated that the HVAC unit was broken, and it took the facility awhile to get the old one replaced. Resident #8 stated they had heat in their own bathroom. The resident stated that the hallways were cold during the time the HVAC unit was broken. The resident stated that they reported the concerns to the previous Director of Environmental Services (DES). The resident stated that facility staff had fans in the hallway to move the air and opened resident room doors so heat would come into the hallways.

During a concurrent observation and interview on 02/27/2024 at 12:44 PM, Resident #5 stated that there was no heat or air conditioning in the hallways for several months on the third floor, from the summer of 2023 until January 2024, because the unit was broken. The resident stated that the hallways were cold and facility staff had to put portable heaters in the hallways.

During an interview on 02/27/2024 at 10:38 AM, Caregiver #4 stated that the facility had issues with the heating unit on the third floor for several months, noting it had just been fixed in January of 2024. She stated facility staff used fans in the hallway on the third floor to keep air moving. She

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stated that, when the third floor HVAC unit was not working, the hallway on the third floor got cold. She stated that each resident room had its own temperature control unit and that each resident set the temperature to what their liking.

During an interview on 02/27/2024 at 12:00 PM, Housekeeping Employee (HE) #7 stated the facility had air conditioning (AC) in the summer, but the third floor was without heat for a couple of months during the winter of 2023 until January 2024, while the HVAC unit was being fixed. She stated they had fans and portable heaters in the hallways to supplement the heat. She stated that the bathrooms connected to the resident rooms had heat.

During an interview on 02/27/2024 at 12:53 PM, the DES stated that, when he started working at the facility in November 2023, the third floor was without heat, and continued without heat until January of 2024. He stated that the unit broke and they had to replace it, noting it took a little while to get it replaced. He stated that facility staff used supplemental heating in hallways to keep the temperature up. He stated that they checked the temperature of the third floor but did not have any documentation of those temperature checks. He stated that no resident complained to him about the lack of heat. He stated he expected residents to have a comfortable environment, including proper heating.

During an interview on 02/27/2024 at 1:00 PM, the Maintenance Assistant (MA) stated he had been employed by the facility for 18 years. He stated that, for several months during the late summer of 2023 to January 2024, the facility did not have a working HVAC unit for the hallways on the third floor. He stated that the unit was

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A1235	Continued From page 37 unrepairable and had to be replaced, which took some time to get installed. He stated that they used a handheld thermometer to measure temperatures on the third floor, but noted that the temperatures were not documented. He stated that it was hot during summer months and cold during winter months, at times, in the third-floor hallway. During an interview on 02/27/2024 at 3:59 PM, the Acting Executive Director stated he was the Director at another facility and was filling in while the current Executive Director was out on medical leave. He stated that every room had their own climate-control unit providing residents the ability to control the temperature in their room. He stated there was problem with the HVAC unit on the third floor around October 2023, noting they had to get a new one installed. He stated that it took until January 2024 to get the new HVAC unit installed and running. He stated that no resident had complained to him about the lack of heating or air conditioning. During an interview on 02/28/2024 at 8:27 AM, the Director of Resident Care stated she did not know the exact timeframe, but in 2023 the facility had to get a new HVAC unit for the third floor. She stated she did not think the temperatures were above or below what regulations required because they used portable heaters and fans for the hallway on the third floor. She stated she did not know if anyone maintained a log of the temperatures for the third floor. She stated that the previous and current DES were responsible for temperature documentation. She stated she expected the facility to have a comfortable environment with a working HVAC system to maintain appropriate temperatures.	A1235		

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A1235	Continued From page 38 During a telephone interview on 02/28/2024 at 10:57 AM, the previous DES stated he was employed by the facility from the summer of 2023 to October 2023. He stated that, when he was hired in the summer of 2023, they did not have a working HVAC unit for the third floor. He stated they obtained estimates to replace the HVAC system, but nothing was ever done. He stated that the hallways got warm in summer, even though they put fans in the hallway. He stated the facility did not want to spend the money to get the HVAC system fixed. He stated that the resident rooms and bathrooms had their own temperature-control units. He stated that the MA was supposed to document the temperatures in an electronic logbook but did not know if he had done so. He stated that the Executive Director was present and aware that the HVAC unit had been inoperable before the previous DES started. He stated Resident #8 had not complained to him about anything. During an interview on 02/29/2024 at 11:04 AM, the Acting Executive Director stated he could not find any documentation that showed facility staff monitored the temperatures on the third floor during the times it was without an HVAC system. He stated he expected the air temperatures to be maintained per regulations and for residents to live in a comfortable environment. During a telephone interview on 02/28/2024 at 11:09 AM, the Executive Director, who had been on medical leave since October 2023, stated that the HVAC unit for the third-floor hallway did not work for several months and was just recently repaired. She stated that the HVAC company evaluated the unit around August of 2023, noting the facility received approval for a capital expenditure to get the HVAC unit replaced with a	A1235		

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A1235	Continued From page 39 new one. She stated facility staff placed fans in the hallways on the third floor to move the air. She said the previous DES and current DES checked the temperature of the hallway on the third floor, but she did not have any documentation of the temperatures while the HVAC was out of service. She stated that the temperatures should have been documented. She stated that she expected the temperatures to be maintained per regulations and for residents to live in a comfortable environment with a functioning HVAC system. Review of a document from the Acting Executive Director titled, "Requested Documents from NJDOH (New Jersey Department of Health)," dated 02/28/2024, indicated that the DES had the temperature of the third floor monitored between October 2023 and January 2024, but he was unable to produce documentation of such temperature monitoring.	A1235		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60a005	A. BUILDING: _____ B. WING _____	C 03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initials Comments TYPE OF SURVEY: Standard with Complaints COMPLAINT #'s: NJ00149240, NJ00151046, NJ00153350, NJ00155359, NJ00168837 CENSUS: 89 SAMPLE: 20 A Recertification, and Complaint Survey was conducted and it was determined that the facilty was not in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures And Standards Applicable To All Licensed Facilities	H 000		
H2640	8:43E-10.6(a)(2)(i) Reporting Serious Preventable Adverse Events With respect to serious preventable adverse events related to health care services provided directly to residents of an assisted living residence, comprehensive personal care home or assisted living program by another health care facility, the facility directly providing the service shall report the event to the Department. This REQUIREMENT is not met as evidenced by: Complaint # NJ00153350 Based on interview and record review, it was determined that the facility failed to notify the Department of Health (DOH) of a serious preventable adverse event that was within the control of the facility for 1 of 20 residents	H2640		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/29/24

Morristown Spring Hills Community

Plan of Action

Executive Director: Jeanny Joseph

Date: 05/07/2024 Revised

Noncompliance:

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

- Regulations/Tag 8:43E-10.6(a)(2)(i) H2640
- Regulations/Tag 843E-13.4(b) H5750
- Regulations/Tag 8:36-2-4(d) A235
- Regulations/Tag 8:36-3.4(a)(1) A310
- Regulations/Tag 8:36-4.1(a)(2) A357
- Regulations/ Tag 8:36-4.1(a)(16) A389
- Regulations/Tag 8:36-5.7(a)(6) A547
-: Regulations/Tag 8:36-7.2(d)(1-18) A709
- Regulations/Tag 8:36-11.5(f) A963
- Regulations/Tag 8:36-14.1(a) A1023
- Regulations/Tag 8:36-15.2 A1051
- Regulations/Tag 8:36-17.5(a)(3)(i-ii) A1235

Corrective Action – Deficiencies

1) **Reporting serious Preventable Adverse Events**: Regulations/Tag 8:43E-10.6(a)(2)(i) H2640

Element #1 Resident #2 identified in the deficient practice expired on NJ EX Order. 264b1

Element #2 All residents within the community have the potential to be affected by the deficient practice. The Director of Resident Care and the Assistant Director of Resident Care will monitor all resident care plans and incident reports monthly to ensure that we have reported all serious preventable adverse events to the Department of Health.

Element #3 Completion Date for the deficiency is 3/08/2024.

Training has been provided to all staff members by the Director of Resident Care and the Assistant Director of Resident Care on the facility's policies and procedures for reporting reportable events to family members, physicians, the Director of Nursing, and NJ Department of Health. Training began on 02/29/2024 and was completed with all staff by March 8, 2024.

Nursing Staff have been trained by the DRC and ADRC in the identifying and documenting procedure of reportable events promptly, as required by state regulations.

The Executive Director and the Director of Resident Care will ensure that all reportable events are called in and reported to The Department of Health within the 24-hr. period.

Element #4 The Director of Resident Care and the Assistant Director of Resident Care will review the 24-hour report to ensure compliance within 48 hours. A weekly review will be conducted by the Executive Director to ensure that we are compliant. **Completion Date for the deficiency is 3/08/2024.**

2) **Universal Transfer form: Mandatory use of Form**: Regulations/Tag 843E-13.4(b) H5750

Element #1 Residents # 6 and resident #9 both still reside within the community.

Element #2 All residents within the community have the potential to be affected by the deficient practice. The Director of Resident Care will ensure that all transfers are sent with a universal transfer form and a copy is uploaded into residents EMR.

Element # 3 The Completion date for the deficiency is 04/12/2024. Training started on 04/01/2024 and was completed with nursing staff by 04/12/2024 about the policy and proper procedures for completing the universal transfer form.

Nursing Staff were trained by the Director of Resident Care on properly filling out the universal transfer form with all necessary information needed before the resident is sent out to the hospital.

Element #4 The Director of Resident Care and/or the Assistant Director of Resident Care will review all transfer records within a 24-to-48-hour period to ensure compliance. A monthly review will be conducted by the Director of Resident Care with oversight of our VP of Nursing, and Regional Nurse to ensure that this is completed. **The Completion date for the deficiency is 04/12/2024.**

3) **Licensure Procedures**: Regulations/Tag 8:36-2-4(d) A235

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

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

Element #3 The Executive Director will ensure that the state surveyor will have full access to the EMR system (PCC).

The access will include but is not limited to resident progress notes, electronic medication Administration Record, and Physicians orders.

The Executive Director will verify full access prior to providing login information to the surveyor. The ED will work with the Corporate System Administrator for PCC to confirm the login information provides full access to the system.

Element #4 The Executive Director will assess login monthly to ensure continued compliance. **Completion date for the deficiency is 04/15/2024.**

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

Element #1 Resident #2 identified in the deficient practice expired on [redacted]

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element #3 The Executive Director, Director of Resident Care, and Assistant Director of Resident Care will ensure that all staff members receive comprehensive training on the facility's policies and procedures. This training will be ongoing and include regular updates to keep staff informed of any changes or revisions. Monitoring immediately, then schedule the first 30 days of review every quarter. Training began on 2/29/2024 and was completed with all staff by 03/08/2024.

The Director of Resident Care will review and assess the implementation of policies and procedures through monitoring and auditing processes monthly. The Executive Director and Director of Resident Care/Assistant Director of Resident Care will check and ensure compliance monthly. This will be done through routine inspections, quarterly quality assurance activities, and monthly reviews of documentation. Finding any areas of noncompliance or gaps in adherence and taking proper corrective actions.

Element #4 The Executive Director will establish clear lines of communication within the facility to ensure that all staff members are aware of the policies and procedures. This will be done by holding monthly communication meetings with the staff to review policies and procedures.

The Executive Director will review monthly and hold staff members accountable for following the company policies, procedures, and state regulatory standards. Establish a system for documenting and addressing instances of noncompliance. Implement disciplinary measures, if necessary, to ensure that all staff members understand the importance of adhering to the policies, procedures, and regulations for resident's rights, safety measures and freedom from abuse/ neglect. **Completion Date for the deficiency is 3/08/2024.**

5) **Resident Rights**: Regulations/Tag 8:36-4.1(a)(2) A357

Element #1 Resident #2 identified in the deficient practice expired on NJ EX Order: 264b1

Element #2 All residents within the community have the potential to be affected by the deficient practice.

The Posting and distribution of the statement of Resident Rights in a conspicuous place. Resident Rights are posted next to the elevator on each floor.

Element #3 All staff members have undergone training in resident rights, including the rights to privacy, dignity, and autonomy, receive prompt medical treatment, Training will emphasize the importance of respecting and upholding residents' rights in all aspects of care and services. Training began on 02/29/2024 and was completed on 03/08/2024.

- The Executive Director will be responsible for posting and distribution statement of Resident Rights in a conspicuous place. Front lobby and on each floor near elevators, this was completed by 03/08/2024.

-The Executive Director will ensure all staff are in-service to resident rights, including the rights to privacy, dignity, autonomy and receive prompt medical treatment. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

-All staff members have undergone training in resident rights, including the rights to privacy, dignity, and autonomy and receive prompt medical treatment. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

- Training will emphasize the importance of respecting and upholding residents' rights in all aspects of care and services. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

Element #4 The Director of Resident Care with support of the Executive Director will review monthly that the nurses maintain thorough and up-to-date documentation regarding resident care changes in conditions and reporting requirements. Make sure they are easily accessible to staff members. This will include nursing notes, care plans, Service plans, Medication administration, and Point of Care tasks. **Completion Date for the deficiency is 3/08/2024.**

6) **Resident Rights**: Regulations/ Tag 8:36-4.1(a)(16) A389

Element #1 Resident #2 identified in the deficient practice expired on NJ EX Order: 264b1. Resident #4 still resides within the community.

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element #3 The Posting and distribution of the statement of Resident Rights in 3 separate resident common areas within the community. The Executive Director, Director of Resident Care, and Assistant Director of Resident Care will ensure that all staff members receive comprehensive training on the facility's policies and procedures. This training will be ongoing and include regular updates to keep staff

informed of any changes or revisions. Monitoring immediately, then schedule the first 30 days of review every quarter.

Nurses, ADRC, and DRC maintain thorough and up-to-date documentation regarding resident care changes in conditions and reporting requirements. Make sure they are easily accessible to staff members. This will include nursing notes, care plans, Service plans, Medication administration, and Point of Care tasks.

- The Executive Director will be responsible for posting and distribution statement of Resident Rights in a conspicuous place. Front lobby and on each floor near elevators. This was completed on 03/08/2024.

-The Executive Director will ensure all staff are in-service to resident rights, including the rights to privacy, dignity, autonomy and receive prompt medical treatment. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

-All staff members will undergo training in resident rights, including the rights to privacy, dignity, and autonomy and receive prompt medical treatment. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

- Training will emphasize the importance of respecting and upholding residents' rights in all aspects of care and services.

- Director of Resident Care and Assistant Resident of Resident are conducted training on Call Bell response time with all nursing staff. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

Element #4 A response to the resident's call bell and/or pendant must be answered within 8 minutes. Rounding will be done at least 3 times per 8-hour shift by the caregiver to minimize risk. Responding to residents' calls for assistance using a call monitoring system will be answered promptly to promote safety and reassurance.

Call bell response times report will be reviewed within a 48-hour period by the Director of Resident Care with support from the Executive Director to ensure compliance. Call bell response times will be reported monthly to the Executive Director and our VP of Nursing, and Regional Nurse. **Completion Date for the deficiency is 3/08/2024.**

7) **General Requirements**: Regulations/Tag 8:36-5.7(a)(6) A547

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

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

Element #3 The Executive Director will ensure that each policy and procedure manual for each department is adhered to and reviewed at least annually. All staff members will receive comprehensive training on the facility's policies and procedures. This training will be ongoing and include regular updates to keep staff informed of any changes or revisions. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

Element #4 Staff personnel records will be audited upon hire and at least annually to ensure compliance. All new hires will have to have completed all necessary pre-hire requirements by their date of hire.

The Business Office Manager with the support of the Executive Director and Director of Resident Care will conduct monthly checks to ensure that all staff licenses are verified through the state website.

The Business Office Manager will conduct full audits of all staff personnel records to ensure compliance is maintained on an annual basis. All staff members will be trained in the facility's policies and procedures, emphasizing the importance of adherence. Training will focus on the specific policies and procedures relevant to their roles and responsibilities. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis. **Completion Date for the deficiency is 3/08/2024.**

8) **Resident Assessments and Care Plans**: Regulations/Tag 8:36-7.2(d) (1-18) A709

Element #1 Resident # 6 still resides within the community.

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element #3 The Director of Resident Care and the Assistant Director of Resident Care will ensure that all nursing staff are trained in the facilities policy and procedures regarding resident Assessments and Care plans. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

Nurses, ADRC, and DRC will maintain thorough and up-to-date documentation regarding resident care changes in conditions and reporting requirements. Make sure they are easily accessible to staff members. This will include nursing notes, care plans, Service plans, Medication administration, and Point of Care tasks. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

Level of care assessment review is completed upon admission, annually, Change of Condition and following hospitalization. The service plan will be completed on the same schedule for all residents.

Element #4 Resident health service plans are to be reviewed every 90 days. The DRC and the ADRC will ensure that this assessment is completed and documented in the EMR.

Through collaboration with the VP of Nursing, and Regional Nurse we will bi-annually evaluate the effectiveness of the training, adherence to policy standards to identify areas for improvement. Use this feedback to revise and refine the policies and procedures, as needed, to better meet the needs of the residents and promote compliance. **The Completion date for the deficiency is 03/08/2024.**

9) **Pharmaceutical Services**: Regulations/Tag 8:36-11.5(f) A963

Element #1 Residents # 6 and #8 still reside within the community. Resident #7 was discharged to a nursing facility for a higher level of care.

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element #3 The Director of Resident Care and Assistant Director of Resident Care will be responsible for ensuring that medications are accurately administrated and documented by authorized individuals, in accordance with prescribed orders. Training will be held with all nursing staff regarding proper medication administration beginning 04/01/2024 and was completed by 04/12/2024.

Training will reinforce proper documentation regarding any missed medication. Timely and continuous follow up with Pharmacy and Physician to reduce occurrences of delayed refills. Training began on 04/01/2024 and was completed by 04/12/2024.

Element #4 The Director of Resident Care and the Assistant of Resident Care will review missed medication report every 24-48 hours to verify compliance. Missed medication report will be reviewed by the Executive Director, the VP of Nursing, and Regional Director of Nursing on a monthly basis, **The Completion date for the deficiency is 04/12/2024.**

10) **Emergency Services and Procedures**: Regulations/Tag 8:36-14.1(a) A1023

Element #1 Resident #2 identified in the deficient practice expired on [redacted] NJ EX Order. 264b1

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element#3 The Executive Director, Director of Resident Care, and Assistant Director of Resident Care will ensure that all staff members receive comprehensive training on the facility's policies and procedures. This training will be ongoing and include regular updates to keep staff informed of any changes or revisions. Monitoring immediately, then schedule the first 30 days of review every quarter. Training began on 02/29/2024 and was completed by 03/08/2024.

The Night Shift from 11 pm – 7 am upon recognition that a resident may need medical attention over and above the basic first Aid, 911 emergency services will be called immediately. Once the responding 911 personnel determines the proper course of action for the resident, the staff on duty are required to notify the Physician, the family, and the DRC.

Day & Evening Shifts are 7 am to 11 pm. The Wellness Nurse on duty will be notified immediately. The Wellness Nurse or Director of Resident Care will evaluate the resident; 911 will be notified. When 911 emergency services are notified, the nurse will notify the physician and family. Should the Wellness Nurse or the Executive Director not be available due to circumstances beyond control, the Aide on duty will notify 911 immediately.

Certified Staff on duty will initiate [redacted] based on resident's code status. [redacted] will be obtained and used if necessary, during cardiac emergencies. A staff list of identified [redacted] certified personnel will be posted in a conspicuous place. Encourage open dialogue and create a culture where staff feel comfortable reporting concerns or seeking guidance when they encounter challenges outside of their role or qualifications.

Regularly review and assess the implementation of policies and procedures through monitoring and auditing processes. Director of Resident Care/Assistant Director of Resident Care will monitor the operations of [redacted] equipment. This will be done through routine inspections, quality assurance activities, and periodic reviews of documentation. Identifying any areas of noncompliance or gaps in adherence and taking proper corrective actions. The following Departments will receive training on [redacted] procedures, including the initiation of CPR on FULL CODE residents. Resident Care, Dining and Recreation. [redacted] training was held by Able Consulting on 03/18/2024.

- Upon hire, certification will be a requirement for the Resident Care Department. Certification verification will be monitored by the Human Resources system with a 30-day renewal reminder.

- Training also covered the proper implementation of Do Not Resuscitate (DNR) orders and the importance of adhering to residents' preferences regarding resuscitation. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

- Staff members will be trained in the facility's code status policy and procedures. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

- Training will emphasize the importance of accurately documenting and communicating residents' code status to ensure appropriate actions in emergency situations. Training began on 02/29/2024 and was completed by 03/08/2024. All staff will be retrained on an annual basis.

The following training was started as of 2/29/2024 with a completion date of 3/8/2024. The Director of Resident Care and Assistant Director of Resident Care conducted and ensured all training is completed.

Element #4 Through collaboration with the VP of Nursing and Regional Nurse we will continuously evaluate the effectiveness of the training, adherence to policy standards to identify areas for improvement. This review will be conducted on a bi-annual basis. We will use this feedback to revise and refine the policies and procedures, as needed, to better meet the needs of the residents and promote compliance.

By implementing these strategies, we expect to create a culture of compliance and ensure that residents' rights are protected, and policies and procedures are followed consistently throughout the community. **The Completion date for the deficiency is 03/08/2024.**

11) **Resident Records**: Regulations/Tag 8:36-15.2 A1051

Element #1 Resident #8 still resides within the community. Resident #7 was discharged to a nursing facility for a higher level of care.

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element#3 The Executive Director will ensure that the state surveyor will have full access to the EMR system (PCC). The ED will work with the Corporate System Administrator for PCC to confirm the login information provides full access to the system.

The access will include but is not limited to resident progress notes, electronic medication Administration Record, and Physicians orders.

The Executive Director will verify by logging in and confirming full access prior to providing login information to the surveyor.

Element #4 The Executive Director will login monthly to the account to ensure compliance.

The Director of Resident Care, with the support of the Executive Director, will ensure proper maintenance and storage of all closed files. We will follow regulatory guidelines for files to be accessible upon request.

Through collaboration with the VP of Nursing, and Regional Nurse, we will on a bi-annual basis evaluate the adherence to policy standards to identify areas for improvement. Use this feedback to revise and refine the policies and procedures, as needed, to better meet the needs of the residents and promote compliance. **Completion date for the deficiency is 04/15/2024.**

12) **Housekeeping-Sanitation-Safety-Maintenance**: Regulations/Tag 8:36-17.5(a)(3)(i-ii) A1235

Element #1 Residents #5 and #8 still reside within the community.

Element #2 All residents within the community have the potential to be affected by the deficient practice.

Element#3 The Executive Director, with the support of the Director of Environmental Services, will ensure that the heating and air conditioning system shall be fully functioning to maintain the required temperature in all areas used by residents.

The Director of Environmental Services or his designee will immediately begin taking the temperature of the area of concern twice daily to ensure that it is within range. Temperature log will be maintained for proper record keeping. This has been implemented effective 04/01/2024 and will be on going.

If the temperature is out of compliance the community will at once bring in additional equipment to assist with proper ventilation until the unit can be repaired and/or replaced.

As this would be deemed a life safety situation the Department of Health would be notified immediately.

Element #4 The Director of Environmental Services, with support of the Executive Director, will continue to ensure that all necessary protocols are implemented until the system is back up and running appropriately. Temperature logs will be reviewed monthly. **Completion date for the deficiency is 04/15/2024.**

Department of Health Surveyors: Jacqueline Jones, RN BSN, CPM, Victoria Register RN, Denise O'Donnell RN, BSN, MBA

Executive Director Signature

5/7/24
Date

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60a005 Y1	A. Building B. Wing Y2	5/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0235	Correction	ID Prefix A0310	Correction	ID Prefix A0357	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed
LSC	04/15/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0389	Correction	ID Prefix A0547	Correction	ID Prefix A0709	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0963	Correction	ID Prefix A1023	Correction	ID Prefix A1051	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. # 8:36-14.1(a)	Completed	Reg. # 8:36-15.2	Completed
LSC	04/12/2024	LSC	03/08/2024	LSC	04/15/2024
ID Prefix A1235	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.5(a)(3)(i-ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60a005 Y1	A. Building B. Wing Y2	5/9/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0235	Correction	ID Prefix A0310	Correction	ID Prefix A0357	Correction
Reg. # 8:36-2.4(d)	Completed	Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(2)	Completed
LSC	04/15/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0389	Correction	ID Prefix A0547	Correction	ID Prefix A0709	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.7(a)(6)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix A0963	Correction	ID Prefix A1023	Correction	ID Prefix A1051	Correction
Reg. # 8:36-11.5(f)	Completed	Reg. # 8:36-14.1(a)	Completed	Reg. # 8:36-15.2	Completed
LSC	04/12/2024	LSC	03/08/2024	LSC	04/15/2024
ID Prefix A1235	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.5(a)(3)(i-ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/15/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/14/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
60a005		5/9/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS AT MORRISTOWN	17 SPRING PLACE MORRISTOWN, NJ 07960

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix H2640 Reg. # 8:43E-10.6(a)(2)(i) LSC	Correction Completed 03/08/2024	ID Prefix H5750 Reg. # 8:43E-13.4(b) LSC	Correction Completed 04/12/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/14/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**