STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315303	A. BUILDING _____ B. WING _____	05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE 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) COMPLETION DATE
F 000	INITIAL COMMENTS Survey date: 5/12/21 Census: 241 Sample: 7 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		7/7/21

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

Electronically Signed | 05/24/2021

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.

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F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

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F 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of records, it was determined that facility staff failed to use the required Personal Protective Equipment (PPE) identified for 1 of 4 staff observed for donning and doffing in a PUI (Person Under Investigation) unit in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was evidenced by the following: On 5/12/21 at 11:40 AM, the surveyor, while touring Executive Order 26, 4.b. (Executive Order 26, 4.b. [redacted]), observed a Housekeeper (HK) inside one of the Executive Ord rooms, and she was not wearing a gown; the HK was wearing the other required PPE. At that time, the surveyor observed the resident room to have a PPE bin outside and a stop sign outside the door that indicated a Special Droplet/Contact Precautions with instructions indicated for everyone to must clean hands when entering and leaving the room, wear a mask, wear eye protection, gown, and glove at the door. On that same date and time, the surveyor interviewed HK, who stated that she should have been wearing a gown and was in-serviced regarding donning and doffing PPE. The HK could not tell the surveyor why she didn't don a	F 880	What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice; Housekeeper was immediately provided with education regarding proper PPE usage in affected areas. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential to be affected. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur; In-service education was provided to all staff regarding correct PPE usage. Additional PPE signage to alert staff to proper usage of PPE Conduct a Root Cause Analysis Facility initiated CDC approved video trainings to all front-line staff: *Keep COVID out (https://youtu.be/7srwrF9MGdw) *for Topline Staff: Module 1 Infection Preventionist Training Course	

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F 880	Continued From page 3 gown when she entered the [Executive Order] room. At 11:45 AM, the surveyor interviewed a 2D Licensed Practical Nurse (LPN) who stated that when entering a [Executive Order] room, staff must put on full PPE, which included an N95 mask, Face-shield/goggles, gown, and gloves. The LPN stated that the HK should have known what to wear before entering the resident's room. At 12:30 PM, the surveyors met with the Licensed Nursing Home Administrator (LPNH) and Director of Nursing (DON) and were made aware of the concerns. At 12:58 PM, the DON stated that the HK was in-service and should have known the proper PPE to donned before entering a [Executive Order] room. A review of the facility Coronavirus, Prevention and Control policy that the DON provided with a revised date of March 31, 2021, indicated "Covid-19 Transmission-Based Precautions: c. "For staff entering the resident's room/providing care: use of N95 mask or equivalent, eye protection, gown, and gloves." NJAC 8:39-19.4 (a) (1) (2) (c)	F 880	(https://www.train.org/main/course/1081350/) Topline staff,IP and all staff Module 6A - Principles of Standard Precautions https://www.train.org/main/course/1081804 How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The date for correction and the title of the person responsible for correction of deficiency The DON or designee will audit one employee donning and doffing PPE weekly for 6 weeks, then monthly for three months, to ensure that proper infection control protocols are in place. Results of the audit will be reviewed by the administrator monthly at the QAPI meeting for 3 months. The Administrator or designee will observe one Housekeeper entering a PUI room weekly for six weeks, then monthly for three months, to ensure that proper infection control protocols are in place. Results of the audit will be reviewed by the QA team quarterly at the QA meeting x2. A RCA was completed and finding were that Housekeeper did not wear a gown because she did no adequately comprehend previous Infection control education provided and there was knowledge gap in employee□s ability to read, understand and follow instructions	

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F 880	Continued From page 4	F 880	noted on appropriate signage. Corrective action included immediate reeducation, improved facility wide education on PPE usage as well as competencies. Frontline staff also viewed the video Keep Covid-19 Out; All staff including Topline and Infection Preventionist viewed Module 6A: Principles of Standard Precautions; Topline and Infection Preventionist viewed Module 1: Infection Prevention & Control Program. Date of Completion July 7, 2021	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315303 Y1	A. Building B. Wing Y2	7/9/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MORRIS VIEW HEALTHCARE CENTER	540 WEST HANOVER AVENUE MORRISTOWN, NJ 07960

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 07/07/2021	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	
5/12/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO